STATE TITLE V BLOCK GRANT NARRATIVE
STATE: SD
APPLICATION YEAR: 2006

I. GENERAL REQUIREMENTS

A. LETTER OF TRANSMITTAL

The Letter of Transmittal is to be provided as an attachment to this section.

B. FACE SHEET

A hard copy of the Face Sheet (from Form SF424) is to be sent directly to the Maternal and Child Health Bureau.

C. ASSURANCES AND CERTIFICATIONS

Copies of the assurances and certifications are maintained in the State Maternal and Child (MCH) program's central office. To receive a copy of the assurances and certifications, contact:

Kayla Tinker, Administrator
Office of Family Health
South Dakota Department of Health
615 East Fourth Street
Pierre, South Dakota 57501-1700
605-773-3737
kayla.tinker@state.sd.us

The MCH program further assures that it will: (1) use funds only for the purposes specified; (2) identify and apply a fair method to allocate funds to groups and localities; (3) apply guidelines for appropriateness and frequency of referrals; (4) use funds only to carry out the purposes of this title; (5) publish charges for services, not impose charges for low income, and adjust charges for income and resources; and (6) at least every 2 years audit expenditures and submit a copy of the audit report to the Secretary.

D. TABLE OF CONTENTS

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published June, 2003; expires May 31, 2006.

E. PUBLIC INPUT

State performance measures were developed based on the state's comprehensive needs assessment. The Department of Health (DOH) made the FY 2006 MCH block grant available for public review and comment via the DOH website at www.state.sd.us/doh. A summary of the plan was put out on the website on May 6, 2005 with comments due back to the DOH by July 1, 2005. Information on how to obtain a complete copy of the application for review was also provided on the website. No written comments were received. In South Dakota, the MCH program interacts daily with the MCH population and related providers. This allows the MCH program to respond to any identified areas of need and build those recommendations into the annual plan prior to the block grant being available for public review.

II. NEEDS ASSESSMENT

In application year 2006, the Needs Assessment must be provided as an attachment to this section.

III. STATE OVERVIEW

A. OVERVIEW

South Dakota is one of the least densely populated states in the nation with 754,844 people living within its 75,955 square miles -- an average population density of 9.9 people per square mile (2000 Census). Over half (34) of the state's 66 counties are classified as frontier (population density of less than six persons per square mile) while 29 are considered rural (population density of six or more persons per square mile but no population centers of 50,000 or more). Three counties are classified as urban (have a population center of 50,000 or more). Of the state's total population, 88.7 percent are White (of which 99.3% are White alone, not Hispanic or Latino), 9.0 percent are Native American and the remaining 2.3 percent are classified as some other race.

According to the 2000 Census, 13.2 percent of South Dakotans live below 100 percent of the federal poverty level (FPL) compared to 12.4 percent for the nation. Over 33 percent (33.1%) of South Dakotans live under 200 percent of the FPL compared to 29.6 percent for the nation. When looking at poverty levels for counties on Indian reservations in the state, these numbers are significantly higher with the four largest reservations (Cheyenne River, Crow Creek, Pine Ridge, and Rosebud) in the state representing the five poorest counties (Dewey, Ziebach, Buffalo, Shannon, and Todd) in South Dakota. The percentage of the population below 100% of the FPL is: Dewey (Cheyenne River)-33.6%; Ziebach (Cheyenne River) - 49.9%; Buffalo (Crow Creek) - 56.9%; Shannon (Pine Ridge) - 52.3%; and Todd (Rosebud) - 48.3%. The percentage of the population below 200% of the FPL is: Dewey - 66.0%; Ziebach - 72.1%; Buffalo - 79.9%; Shannon - 77.7%; and Todd - 73.4%.

According to the 2000 Census, 26.8% of the state's population are children (under the age of 18) while 6.8% is age 4 or younger. Over 41 percent (41.5%) of the state's female population is considered to be of childbearing age (aged 15 through 44). South Dakota resident pregnancies totaled 11,846 in 2004 (21 of those were to women not in the 15-44 year age range). Pregnancies were estimated by totaling resident births (pregnancies producing at least one live birth), fetal deaths and abortions.

Access to primary care physicians is limited in the state. According to the South Dakota Board of Medical and Osteopathic Examiners, there were 712 active primary care physicians licensed to practice in South Dakota as of February 2005. Of those, 336 were family physicians, 207 practiced internal medicine, 78 were pediatricians, 58 were OB/GYNs, and 33 were general practitioners. There are also 612 primary care midlevel providers -- 305 physician assistants, 291 nurse practitioners and 16 nurse midwives located in the state. About two-thirds of the state is designated by the federal government as a Health Professional Shortage Area.

South Dakota has 50 general community hospitals, of which 36 are critical access hospitals (CAHs), as well as five Indian Health Services (IHS) hospitals and three Veterans Administration hospitals. There are 28 federally qualified health centers (FQHCs) and 55 rural health clinics.

The economic status of individuals in the state, particularly the Native American population, is a major barrier to access to services. Another factor to consider is transportation to access services. For some, this means traveling great distances (over 50 miles) to see a primary care provider, and even further to see a specialist. On the Indian reservations, this problem is further complicated by the lack of a reliable transportation system.

Temporary Assistance for Needy Families (TANF) -- TANF is a temporary public assistance program administered by the Departments of Social Services (DSS) and Labor. TANF is a needs-based program for families with children under the age of 18 (or under the age of 19 if the child is in high school) who need financial support due to: (1) death of a parent(s); (2) parent(s) absence from the home; or (3) physical/mental incapacity or unemployment of a parent(s). The primary focus of the state TANF program is to help families help themselves by promoting family responsibility and accountability and encouraging self-sufficiency through work. For state FY 2004, there were 4,992 children receiving TANF benefits (195 less than FY03).

Children's Health Insurance Program (CHIP) -- CHIP provides free health insurance to children under age 19 who meet certain eligibility guidelines. CHIP covers doctor's appointments, hospitals stays, dental/vision services, prescription drugs, mental health care, and other medical services. CHIP provides health insurance coverage to uninsured children whose family income is up to 200% of FPL. Children who already have private health insurance may also be eligible for CHIP to pay deductibles, co-payments and other medical services not covered by their private policy. At the end of FFY 2003 (ending 09-30-03) total enrollment in CHIP was 62,733.

B. AGENCY CAPACITY

The DOH is charged with the protection of the public health by appropriate measures set forth and authorized by state law. The DOH is designated as the sole state agency to receive, administer and disburse federal Title V monies. South Dakota Codified Law (SDCL) 34-1-21 authorizes the DOH to adopt rules to administer the Title V program relating to MCH and children with special health care needs (CSHCN) services. Administrative Rules of South Dakota (ARSD) 44:06 provides guidance on the delivery of children's special health services (CSHS) and outlines general operation of the program, eligibility requirements, providers, family financial participation, claims, and scope of benefits. SDCL 34-24-17 requires all infants born in South Dakota to be screened for the metabolic diseases of phenylketonuria (PKU), hypothyroidism and galactosemia and ARSD 44:19 contains the rules regulating metabolic screening. These rules were recently updated to expand the metabolic screening requirements to include biotinidase deficiency, congenital adrenal hyperplasia, hemoglobinopathies, amino acid disorders, fatty acid oxidation disorders, and organic acid disorders. Screening for cystic fibrosis will be made available on an optional basis.

The Division of Health and Medical Services (HMS) is the health care services delivery arm of the DOH and administers MCH services. HMS consists of four offices and the State Epidemiologist.

OFFICE OF FAMILY HEALTH (OFH) -- OFH administers the MCH Block Grant for the DOH. OFH provides leadership and technical assistance to assure systems that promote the health and well-being of women of reproductive age, infants, children, and youth, including those with special health care needs and their families. OFH staff provide training and ongoing technical assistance to DOH field staff as well as private health care providers who deliver MCH services. Staff are responsible for the development of policies and procedures relevant to the delivery of MCH services for pregnant and postpartum women, infants, children, adolescents, and CSHCN. OFH works closely with field staff on data collection needed for federal and state reports as well as for program evaluation.

The Children's Special Health Services (CSHS) program directs care coordination services for children with chronic illness, disabling conditions and other special health care needs. CSHS also coordinates diagnostic and consultative outreach and telemedicine pediatric specialty clinics and provides financial assistance for specified conditions and procedures on a cost share basis. Eligibility for the CSHS program was expanded in 2004 to include individuals up to age 21.

The Perinatal program provides direction and technical assistance for primary and preventive care for women and infants including risk assessment and care coordination of pregnant women, perinatal education, prenatal/Bright Start home visits, developmental screenings, immunizations for infants/toddlers, sudden infant death syndrome (SIDS), and newborn metabolic and hearing screenings.

The Newborn Metabolic Screening Program helps identify babies who may have a metabolic disorder and alerts the baby's physician to the need for further testing and special care. As was noted earlier, beginning June 1, 2005, South Dakota expanded the number of mandated newborn screening disorders from three (PKU, hypothyroidism and galactosemia) to 32. The additional tests will include biotinidase deficiency, congenital adrenal hyperplasia, hemoglobinopathies, amino acid disorders, fatty acid oxidation disorders, and organic acid disorders. Screening for cystic fibrosis will be made available on an optional basis.

The Newborn Hearing Screening Program works with hospitals to encourage screening for hearing loss before babies go home from the hospital or by one month of age. The program also works to ensure health care providers and parents are informed about the benefits of early hearing screening and that follow-up is provided to infants referred for further hearing evaluation. The Newborn Hearing Screening Program utilizes the Electronic Vital Records and Screening System (EVRSS) to determine which infants have been screened/not screened as well as which infants need rescreening and/or follow-up.

The Women, Infants and Children (WIC) program promotes and maintains the health and well-being of nutritionally at-risk women, infants and children up to age five. Clients must meet income eligibility and be at nutritional risk. WIC provides: (1) nutrition education and counseling; (2) breastfeeding support (i.e., information and breast pumps); (3) healthy foods; (4) referrals to doctors, nurses, and health/social service agencies; and (5) immunizations, if needed.

The Family Planning program officers men and women of childbearing age reproductive health education, contraceptive counseling and methods, physical examinations, and sexually transmitted (STD) counseling, testing and treatment. Payment for family planning services is based on a sliding fee schedule according to family size and income.

The Child/Adolescent Health program coordinates a variety of programs designed to promote health, prevent disease and reduce morbidity and mortality among children and adolescents including abstinence, school health guidance and intentional/unintentional injury prevention.

OFFICE OF HEALTH PROMOTION (OHP) -- OHP coordinates a variety of programs designed to promote health and prevent disease. In addition to the programs below, the DOH recently hired a chronic disease epidemiologist to assist with the integration of chronic disease epidemiologic services throughout the DOH and provide support, technical assistance and guidance as needed.

The All Women Count! (AWC) Breast and Cervical Cancer Control program coordinates statewide activities to promote early detection of breast and cervical cancer. Mammograms, Pap smears and related exams are available at no cost to eligible women at many doctors' offices, mammography units, family planning and other health clinics throughout the state. AWC serves women 30-64 years of age for Pap smears, 50-64 for mammograms, who are without insurance to pay for screening exams, or who have insurance but cannot pay the deductible or co-payment. The Cancer Registry program ensures the coordination of cancer reporting in the state.

The AWC Chronic Disease Screening program is an expansion of the All Women Count! program and includes cardiovascular and diabetes screening for eligible women enrolled in the AWC program. The expanded program reimburses health care providers for screening, diagnosis, and patient education for diabetes and cardiovascular disease. Women not only are screened for cardiovascular disease and diabetes but also can be seen by a professional for four physical activity and nutrition sessions per year.

The Cardiovascular Health program promotes healthy communities through prevention, detection, and monitoring of cardiovascular diseases within South Dakota. The goal of the program is to prevent cardiovascular disease through public and professional education and partnerships with communities to educate, promote healthy lifestyle behaviors, and build skills to initiate environmental and policy change strategies. The program focuses on primary prevention where risk factors such as physical activity, nutrition, elevated blood pressure and elevated blood cholesterol can be addressed.

The Coordinated School Health Program provides technical guidance and services to schools and is jointly administered with the Department of Education (DOE).

The mission of the Diabetes Prevention and Control program is to design, implement, and evaluate public health prevention and control strategies that improve access to, and quality of, diabetes

education for all persons with diabetes in South Dakota; to reach those communities most impacted by the burden of diabetes; and to deliver a broad range of public health activities that will reduce death, disability, and costs related to diabetes and its complications.

The Oral Health Program coordinates programming to increase awareness of the importance of oral health and preventive care, foster community and statewide partnerships to promote oral health and improve access to dental care, and promote the use of innovative and cost effective approaches to oral health promotion and disease prevention.

The Public Health Nutrition Program is responsible for developing and managing nutrition activities for the DOH. The State Nutritionist serves as a spokesperson on issues that affect the nutritional health of the state and recommends appropriation nutrition interventions.

The Tobacco Prevention and Control Program coordinates state efforts to prevent young people from starting to use tobacco products, help current tobacco users quit, and reduce non-smokers' exposure to second-hand smoke.

OFFICE OF COMMUNITY HEALTH SERVICES AND PUBLIC HEALTH ALLIANCE (OCHS/PHA) - This office provides professional nursing and nutrition services and coordinates health-related services to individuals, families and communities across the state. Services include education and referral; immunizations; developmental screenings; management of pregnant women; WIC; family planning; nutrition counseling and education; screenings for vision, hearing, blood pressure, blood sugar, and hemoglobin; and many more. In most counties, these services are delivered at state DOH offices. In 12 Public Health Alliance sites, the office coordinates the delivery of services through contracts with local county governments and private health care providers.

OCHS also administers the Bright Start home visiting program. This program is a community-based program in Sioux Falls and Rapid City that provides home visiting services to high risk families during pregnancy, after delivery, and may continue until the child's third birthday. The program focuses on high risk pregnant mothers and new parent families with limited economic and/or social and health resources. Ideally, the visits begin during the pregnancy but can begin whenever the family is referred to the program. Interventions with the pregnant woman/family include: (1) prenatal, maternal and infant/child health assessments and education; (2) infant/child development assessments; (3) parenting education; (4) health, safety and nutrition education; and (5) linking families with other resources in the community to maximize their overall functioning. The Bright Start home visiting program began in April 2000. The following numbers of families have been served by the program: 246 in FY 2001, 323 in FY 2002, 331 in FY 2003, and 395 in F4Y 2004. The goal of the Bright Start Program is to enhance the family's ability to care for itself and have a healthy baby. The program helps individuals and families identify strengths and assists the family utilize and build on these strengths and skills.

OFFICE OF DISEASE PREVENTION (ODP) -- ODP provides vaccines for South Dakota's children to prevent such childhood diseases as measles, mumps, rubella, varicella, HiB, hepatitis B, and bacterial meningitis and provides recommendations and education on adult immunizations such as influenza, pneumonia and tetanus. Staff investigate sources of STD infection, provide treatment and apply preventive measures to those exposed. Field offices provide confidential counseling and testing for HIV/AIDS as well as educational materials, training for the public, schools and health care providers, and assistance with health care costs for those with HIV disease. The office provides tuberculosis (TB) clinics and contracts with the private medical sector for evaluation, treatment and follow-up of TB cases. ODP also conducts disease outbreak investigations in the state.

STATE EPIDEMIOLOGIST -- The State Epidemiologist integrates epidemiologic services throughout the DOH and provides support, technical assistance and guidance as needed.

C. ORGANIZATIONAL STRUCTURE

The DOH is an executive-level department with the Secretary of Health appointed by, and reporting to, the Governor. The mission of the DOH is to prevent disease and promote health, ensure access to necessary, high quality care at a reasonable cost, and efficiently manage public health resources. In 2004, the DOH released its DOH 2010 Initiative which provides a clear, concise blueprint for the future activities of the department. The Initiative outlines the goals and objectives for the department as well as key performance measures which will allow the department to monitor progress toward these goals. The Initiative also provides detailed action steps for each goal to help guide department activities. Additionally, specific individuals have been assigned the responsibility of leading the action steps needed to attain each of the 13 objectives. A copy of the initiative is attached.

The DOH is organized into three divisions -- Health and Medical Services, Administration, and Health Systems Development and Regulation. As was mentioned above, HMS is the health care services delivery arm of the DOH. A detailed description of HMS offices and activities is provided under "Agency Capacity".

The Division of Administration provides centralized support to DOH programs including financial management, computer systems, communications, health planning, legislative coordination, grant writing, and research. The division also provides oversight of the state's correctional health care system. The Office of Data, Statistics and Vital Records (DSVR) provides technical assistance for the development, implementation and evaluation of data collection activities. DSVR has an FTE to oversee data collection and analysis activities for the MCH block grant. DSVR maintains the vital records system for the state including births, deaths, marriages, divorces, and fetal deaths and issues certified copies of such records. The State Public Health Laboratory provides testing, consultation, and expert testimony in support of local, state and federal government agencies and the general public.

The Division of Health Systems Development and Regulation (HSDR) administers regulatory programs related to health protection and health care facilities including the traditional public health areas of sanitation and safety, inspection and licensure of public facilities and Medicaid/Medicare survey and certification of health care facilities and providers. The Office of Rural Health (ORH) works to improve the delivery of health services to rural/medically underserved communities with an emphasis on access. Specific program examples include recruitment of health professionals, technical assistance to health care facilities, development and use of telemedicine applications, and general information and referral. The Office of Pubic Health Preparedness and Response directs the state's bioterrorism/public health emergency response. A portion of the DOH's bioterrorism funding has been utilized to strengthen the public health infrastructure in South Dakota including improvements in communication and computer systems for MCH field staff.

Copies of DOH organizational charts are available upon request from the MCH Program Administrator.

D. OTHER MCH CAPACITY

Preventive and primary care services to the MCH population are provided through OCHS. OCHS provides direction to state-employed nurses, nutrition educators and dietitians for the provision of community health services in the state. Field staff providing primary preventive services for mothers, infants and children include 6.8 FTE for mothers and infants and 7.4 FTE for children and adolescents. Another 5.8 FTE provide family planning services in the state.

The service delivery system for CSHCN is a regional system with 17.75 FTE (including nursing, dietitian and social work) staff providing services at offices in Pierre, Sioux Falls, Aberdeen, and Rapid City. Services are provided in a community-based manner that enable families to receive appropriate consultation and care planning as close to home as possible. Pediatric specialty clinics are held in each of the four offices. In addition, pediatric specialists, dietitians, registered nurses, and

social workers function as a multi-disciplinary team with families to assist them in meeting the needs of CSHCN. The CSHS service delivery system represents a unique public-private partnership between the DOH and numerous hospitals and physicians across the state.

OFH and OHP central office program staff dedicated to providing program direction to specific MCH Program areas include: 0.61 FTE for child and adolescent health; 1.74 FTE for perinatal health; 0.94 FTE for family planning services, and 1.11 FTE for CSHS.

Kayla Tinker, RN, is the administrator of OFH and also serves as the MCH Program Administrator. Kayla has served in this capacity since December 1999. Prior to this position, Kayla served as the Administrator of the Office of Public Health Alliance for three years and was a community health nurse supervisor for the DOH for over six years. Barb Hemmelman is the MCH Program Coordinator and also serves as the CSHS program coordinator. In this capacity, Barb directs care coordination services for CSHCN and coordinates diagnostic and consultative outreach/specialty clinics. Barb has been with the DOH since September 2004 and previously worked as the Director of the state's early intervention within the Department of Education, Office of Special Education. Everett Putnam has been with the DOH since December 1988 as a statistician and serves as the MCH State Data Contact. More detailed biographies for these positions are attached. Other MCH team members include the following:

- Linda Ahrendt, Physical Activity
- Darlene Bergeleen, Administrator, Office of Community Health Services
- Kristin Biskeborn, State Nutritionist
- Julie Cholik, Child and Adolescent Health Coordinator/CSHS Nursing Consultant
- Jacy Clarke, Chronic Disease Epidemiologist
- Terry Disburg, Newborn Hearing/CSHS Nurse Consultant
- Bev Duffel, Family Planning Director
- Josie Peterson, Office of Rural Health
- Julie Ellingson, Oral Health
- Lucy Fossen, Newborn Metabolic Screening
- Lon Kightlinger, State Epidmiologist
- Kathi Mueller, Administrator, Office of Data, Statistics and Vital Records
- Nancy Shoup, Perinatal Nursing Consultant
- Susan Sporrer, Division of Administration
- Colleen Winter, Administrator, Office of Health Promotion

Through a contractual arrangement, South Dakota Parent Connection provides parent consultant and training services for CSHS. Parent Connection identifies and recruits parents of CSHCN to provide mentoring and peer support to other families with CSHCN. They provide a family perspective to CSHCN program staff regarding programs, policies and procedures, maintain a statewide database of support parents and groups, provide parent-to-parent training, and link parents throughout the state with trained supporting parents in a community-based manner. This relationship was formalized in 1999 and continues to expand and enhance family involvement in the CSHS program.

E. STATE AGENCY COORDINATION

South Dakota's public health system includes the DOH, community health centers (CHCs), IHS, and tribal health representatives. While many states use local health departments to deliver public health services, in South Dakota these services are delivered by the DOH and funded primarily with federal or state resources. There is only one local health department in the state located in Sioux Falls. However, its primary focus is on environmental health issues.

Representatives from the DOH and the Community HealthCare Association of the Dakotas (CHAD) continually explore ways to increase collaboration and coordination of health services such as MCH,

family planning, community health, and communicable disease control. In some areas, DOH staff are co-located with CHCs. Where feasible, local DOH staff meet regularly with CHC staff to address identified needs and facilitate the development of a seamless system of care.

IHS delivers services to the Native American population on the state's nine reservations. There are IHS hospitals in Eagle Butte, Pine Ridge, Rapid City, Rosebud, and Sisseton. On many of the reservations, tribally-appointed community health representatives also provide services.

The DOH and DSS have an interagency agreement to establish and assure referral mechanisms between agencies. The intent of the agreement is to maximize utilization of services and assure that services provided under Title V and Title XIX are consistent with the needs of recipients and that the objectives and requirements of the two programs are met. The agreement establishes procedures for early identification and referral of individuals under age 21 in need of services such as early and periodic screening, diagnostic and treatment (EPSDT), family planning, case management, and WIC. Representatives from both agencies meet regularly to discuss carious issues including care coordination of high-risk pregnant women, referral mechanisms, outreach for Medicaid, and CHIP.

The DOH has a number of information and referral mechanisms to assist in the identification and enrollment of eligible children for Medicaid eligibility such as WIC, CSHS and OCHS/PHA. WIC facilitates referrals and links applicants with services so that families can access Medicaid as well as other health and social programs. In addition to the State program, there are three tribally-operated WIC programs on the Cheyenne River, Rosebud and Standing Rock Indian reservations. Coordination between the WIC and Medicaid program occurs as all Medicaid eligibility approvals of pregnant women are automatically reported to the WIC program on a weekly basis. OCHS/PHA staff serve as an information and referral source to inform families of Medicaid availability and facilitate enrollment in Medicaid by referral.

The South Dakota Family Planning Program provides services to 4,357 adolescents under the age of 19. Of these, 1,659 were between the ages of 15-17 and 4,150 were females. Through Title X Special Funding for Regional Priorities funding, Downtown Women's Health Care in Sioux Falls provided community education on reproductive health topics to 6,422 adolescents in the Sioux Falls area.

The South Dakota Family Planning Program also received additional Title X funding to increase male involvement in family planning and reproductive health. Through a partnership with Boys and Girls Clubs of South Dakota, 111 young men aged 9-15 participated in the SMART Moves Primary Prevention Program between September 1, 2004 and December 31, 2004. The program was provided by clubs in Watertown, Aberdeen, Brookings, Fort Thompson, Wagner, and Eagle Butte.

Youth & Family Services (YFS) in Rapid City received Title X Family Planning funding directly from the Office of Population Affairs for a National Male Research and Demonstration Project. Through this grant, YFS provides the Wise Guys curriculum in Rapid City and surrounding areas.

In 2003, the South Dakota Legislature passed a concurrent resolution supporting the creation of a South Dakota plan for suicide prevention. The resolution recognizes that suicide is a significant problem in the state and declares that prevention of suicide be made a state priority by strengthening the private and public entities charged with addressing the problem. The overarching goals of the suicide plan include:

• Implement effective, research-based suicide prevention programs to reach the public and at-risk populations, such as the elderly, Native Americans, youth/young adults, and rural communities;
• Provide schools with guidelines to develop effective suicide prevention programs;
• Develop public information campaigns designed to increase public knowledge of suicide prevention;
• Work with postsecondary schools to develop effective clinical and professional education on suicide;
• Assure that schools have effective linkages with mental health and substance abuse services; and
• Implement effective, comprehensive support programs for survivors of suicide.

The DOH collaborates with DHS Divisions of Mental Health and Alcohol and Drug Abuse to address issues affecting children and adolescents and their families such as suicide, tobacco use, FAS, and HIV prevention. DOH staff provide assistance and representation on the Division of Alcohol and Drug Abuse Advisory Council Safe and Drug-Free Schools application reviews and the Mental Health Planning and Coordination Advisory Council's Children Subcommittee.

DHS administers the state's Respite Care Program. The program is jointly funded with state general funds, MCH block grant funds and some DSS federal grant funds. The Respite Care Program offers services statewide. MCH block grant funds are expended to provide services for children on the program diagnosed with chronic medical conditions. CSHS staff assist families with referral to the Respite Care Program. The program has an advisory group with representation from various state programs serving families who have children with special needs including special education, child protection, developmental disabilities, mental health, and CSHCN. Parents are also represented on this group.

DHS and the Social Security Administration (SSA) have an expanded joint powers agreement with the DOH to assure that SSI child beneficiaries under age 18 are provided appropriate outreach, referral, disability determination, and rehabilitation services. Expansion of the agreement enables increased collaboration with DHS to promote coordination and delivery of services for children with severe emotional disturbances or developmental disabilities. The CSHS program manager is the DOH Title V liaison with DHS and SSA.

South Dakota receives funding from CDC for a Coordinated School Health Program (CSHP) to support a collaborative relationship between DOE and DOH in an effort to help local schools implement and coordinate comprehensive school health programs directed toward the three CDC priority areas of nutrition, physical activity and tobacco. DOH and DOE have a MOA that outlines areas of responsibility and requirements to implement the program and have developed a very effective relationship that allows for maximum use of financial and staffing resources. CSHP collaborates with Game, Fish and Parks to offer the "Fantastic Fourth Grade Field Trip" to fourth grade teachers at no cost. Each teacher receives a packet of information including core content based lessons and physical activity options while visiting the park. The "South Dakota Healthy School Awards" are given to schools in three categories -- elementary, high school and district-wide -- that exemplify healthy programs and policy.

Delta Dental Plan of South Dakota and Ronald McDonald House Charities have created a Ronald McDonald Care Mobile program in South Dakota. In September 2004, Delta Dental was granted a Ronald McDonald Care Mobile van with two fully equipped dental operatories which will travel statewide to increase access to care in underserved areas of South Dakota. As a key partner with Delta Dental, the DOH has committed to staffing and coordinating services, as well as allocating resources to aid in providing oral health education resources, immunizations, and assistance in maintaining a referral system for patients of the Care Mobile. Providing primary dental care to children in these remote areas will emphasize the importance of preventive measures such as early intervention and continuing oral health education.

Since September 2004, the Ronald McDonald Care Mobile has visited 16 communities across the state with 1,652 children receiving preventive services on the Care Mobile. Of those, 862 were Medicaid/SCHIP enrolled children. Delta Dental reports that 53% of the children receiving services on the Care Mobile also required restorative dental care. The number of children needing multiple appointments and the extent of the disease in the population served has resulted in the need to revise initial Care Mobile goals by decreasing the total number of children seen in a year.

The DOH has a long-standing collaborative relationship with the Center for Disabilities within the USD School of Medicine's Department of Pediatrics. The South Dakota Leadership Education Excellence in Caring for Children with Neurodevelopmental and Related Disorders (LEND) is a program of the Center for Disabilities that works to improve the health status of infants, children and adolescents with neurodevelopmental and related disabilities. The LEND program provides one year of specialized

training which focuses on the interdisciplinary training of professionals for leadership roles in the provision of health and related services to infants, children and adolescents with neurodevelopmental and related disabilities and their families. The program augments graduate studies in the disciplines of audiology, health administration, medicine, nursing, nutrition, speech-language pathology, occupational therapy, pediatric dentistry, physical therapy, psychology, and public health social work. Both the Title V MCH director and CSHS director serve on the LEND advisory group. In addition to LEND, MCH and the Center for Disabilities collaborate on a number of training and other interagency projects.

F. HEALTH SYSTEMS CAPACITY INDICATORS

HSCI #01: The rate of children hospitalized for asthma (10,000 children less than five years of age).

See Health Systems Capacity Indicator form (Form 17).

HSCI #02: The percent of Medicaid enrollees whose age is less than one year who received at least one initial periodic screen.

In South Dakota, the goal is to increase the adequacy of primary care for Medicaid enrollees. The rate of Medicaid enrollees less than one year of age who were screened fluctuated, but changed very little between 200 and 2004. During the observation period, a median of 4,423 infants were screened annually out of a median of 5,322 enrolled annually. The lowest rate was 83.1% in 2002, while the highest rate was 86.6% in 2001. See Health Systems Capacity Indicator form (Form 17) for further detail.

HSCI #03: The percent of State Children's Health Insurance Program (SCHIP) enrollees who age is less than one year who received at least one periodic screen.

The rate of infants less than one year of age enrolled in SCHIP who were screened increased to 100% during the observation period, 2000-2004. In 2000, 63% of the 54 enrolled infants were screened. This increased to 100% in 2003 and 2004 when all of the 90 and 92 enrolled infants were screened, respectively. See Health Systems Capacity Indicator form (Form 17).

HSCI #04: The percent of women (15 through 44) with a live birth during the reporting year whose observed to expectant prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.

Adequate prenatal care is vital for the success of the pregnancy and well-being of the infant and mother. The DOH goal is to increase the adequacy of prenatal care utilization among South Dakota mothers. The Kotelchuck Index uses birth certificate data to assess the adequacy of prenatal care utilization and classified the start of prenatal care and the number of prenatal visits. An Index value of 80% and greater is considered adequate. The Index does not measure the quality of prenatal care. In South Dakota, between 2000 and 2004, the percent of mothers with a Kotelchuck Index of > 80% decreased slightly. Over the five-year observation period, there were 52,911 qualifying births with 41,182 (78%) achieving > 80% Kotelchuck Index. The 80% achievement rates ranged from 76% to 79% during the five year period (see Health Systems Capacity Indicator form (Form 17)).

A need was identified to gather additional data from providers on their practices and beliefs regarding prenatal care. As a result, a survey was developed and disseminated to health care providers to gather their perceptions as to why pregnant women did or did not receive early and regular prenatal care. Survey results are currently being analyzed and the report is pending.

HSCI #05: Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the state.

There is a significant difference in utilization of prenatal services in the first trimester among Medicaid

and non-Medicaid women. In 2003, only 70% of Medicaid women accessed prenatal care in the first trimester, while 83% of non-Medicaid women did so. Low birth weight is also another indicator that is varying between Medicaid vs. non-Medicaid mothers. In 2003, 8% of babies born to Medicaid mothers were <2500 grams, as compared to 6% of non-Medicaid babies. The rate of infant deaths among the two groups varies greatly as well. In 2003, the Medicaid infant death rate is 8.4 per 1,000 live births compared to 5.5 per 1,000 for the non-Medicaid population. Although the rates have improved considerably since 1999, the disparities among the Medicaid and non-Medicaid population are still apparent. See Health Systems Capacity Indicator Form (Form 18) for further detail.

HSCI #06: The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs for infants (0 to 1), children and pregnant women.

Children aged 0-5, enrolled in Medicaid prior to July 1, 1998 were required to be at 133% of FPL and children ages 6-18 were to be at 100% of the FPL. Pregnant mothers had to be below 133% as well. The new Medicaid guidelines, implemented in April 1, 1999 stated that children ages 0-18 were to be under 140% of the FPL and pregnant women below 133% of FPL. Pregnant women are not eligible for SCHIP benefits. Prior to 1999, infants 0-1 were not eligible as well. From 1999-2000, infants and children were required to be at 133% of FPL to be eligible for the program. In 2001, the prerequisite was changed to 200% of FPL. See Health Systems Capacity Indicator Form (Form 18).

HSCI #07: The percent of EPSDT-eligible children aged 6 through 9 years who have received any dental services during the year.

See Health Systems Capacity Indicator Form (Form 17).

HSCI #08: The percent of state SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) program.

The DOH collaborates with SSA and DHS programs serving children with chronic and disabling medical conditions, severe emotional disorders or developmental disabilities and promotes outreach and access to rehabilitative services, mental health services, medical care, and service coordination. An ongoing joint powers agreement between DOH, DHS and SSA assures that SSI child beneficiaries and potential beneficiaries under the age of 18 years are provided appropriate outreach, referral, disability determination, and rehabilitation services. See Health Systems Capacity Indicator Form (Form 17) for further detail.

HSCI #09A: The ability of State to assure Maternal and Child Health (MCH) program access to policy and program relevant information.

See Health Systems Capacity Indicator Reporting and Tracking Form (Form 19).

HSCI #09B: The ability of States to determine the percent of adolescents in grades 9 through 12 who report using tobacco products in the past month.

See Health Systems Capacity Indicator Reporting and Tracking Form (Form 19).

HSCI #09C: The ability of States to determine the percent of children who are obese or overweight.

See Health Systems Capacity Indicator Reporting and Tracking Form (Form 19).

IV. PRIORITIES, PERFORMANCE AND PROGRAM ACTIVITIES

A. BACKGROUND AND OVERVIEW

The DOH priority needs are based on the needs assessment completed for the FY 2005 South Dakota MCH Block Grant application. Priority needs in South Dakota cross the four levels of the public health services pyramid. The DOH has identified the following MCH priority needs: (1) reduce unintended pregnancies; (2) reduce infant mortality; (3) improve pregnancy outcomes; (4) reduce morbidity and mortality among children and adolescents; (5) improve adolescent health and reduce risk taking behaviors (i.e., intentional and unintentional injuries, dietary habits, tobacco use, alcohol use, and other drug utilization); (6) improve the health of, and services for, CSHCN through comprehensive services and support; (7) improve and assure appropriate access to health services that are focused on families, women, infants, children, adolescents, and CSHCN; (8) improve state and local surveillance and data collection and evaluation capacity; and (9) reduce childhood obesity.

The priority setting process is an ongoing and evolving process. Systems development for women, infants, children, adolescents, and CSHCN is an integral part of the MCH planning process and includes analyzing of current programs and services, identifying gaps in services, establishing appropriate goals and objectives, collaborating with partners, and establishing methods for monitoring and evaluating programs and services to ensure that goals and objectives are met. As was mentioned earlier, the MCH team has used the CAST 5 self assessment tool to examine existing capacity and assist programs in aligning efforts within an overall system and population-based approach and smaller workgroups have been established to start to address the identified needs in data capacity and infrastructure building.

The MCH team also initiated a MCH Assessment, Planning and Monitoring Process which is data driven, with the starting point of assessing the needs of the MCH population groups using Title V health status and system capacity indicators, performance measures, and other quantitative and qualitative data. The process focuses on needs, priorities, targets, and activities -- not specific programs or individuals. The MCH Team began the process with the child and adolescents population group. The Team discussed national and state performance measures, determining if objectives were met or unmet. Health system capacity and health status indicators, and data sets used were analyzed. Additional data sources to assist in assessment of this population group were identified. Ongoing and emerging issues impacting this population group were also identified. As a result of this process, a matrix was developed that identified needs, data sources, performance measures and indicators relevant to the needs, linkage to HP 2010 Objectives, gaps in data or data needs, and identification of a lead agency. The MCH Team then determined level of responsibility relative to the MCH Program. This process allowed for prioritization of the needs of this population group and the role of MCH in addressing them. Current activities and new or proposed activities were discussed to meet the needs, as prioritized.

B. STATE PRIORITIES

As a result of the MCH assessment, South Dakota has developed seven performance measures that relate directly to identified priority needs. Priority needs in South Dakota, as well as the respective performance measures and activities that address these needs, cross the four levels of the core public health infrastructure pyramid -- direct services, enabling services, population-based services, and infrastructure building services.

Direct service interventions will improve health status and reduce adverse outcomes. Since enabling services facilitate and enhance direct services, activities in both levels of the pyramid will address the state's priorities. There are several priority needs that primarily impact the population-based service level. Again, in order to accomplish improvement in the state's priorities, there must be education and service interventions at both the direct and enabling service levels. Conversely, effective interventions at the direct and enabling services levels require the accompaniment of population-based education and other activities.

All state priority needs have elements of infrastructure building services. The development of an interagency collaborative infrastructure is critical to reducing barriers to care and improving health outcomes. Improved state and local surveillance, data collection and evaluation capacity facilitates data-driven decision making regarding allocation of resources and strategies to address the priority needs. Coordination, quality assurance, standards development, and monitoring must accompany interventions to reduce barriers to care and improve and assure appropriate access to health services focused on families, women, infants, children, adolescents, and CSHCN.

SPM 1: Percent of women who smoked prior to pregnancy and report they stopped during pregnancy.
Smoking during pregnancy increases the risk of miscarriage, stillbirth and preterm/low birthweight infants. Improved pregnancy outcomes have been demonstrated when women significantly decrease or stop smoking during pregnancy. Activities related to this performance measure will impact infant mortality in the state.

SPM 4: The rate (per 1,000 live births) of children under age one who die as a result of Sudden Infant Death Syndrome.
Sudden Infant Death Syndrome (SIDS) is occurring over three times as much in the Native American population than in the White population. One of the most important things to help reduce the risk of SIDS is to place healthy babies on their backs when they sleep. Education is an important piece to helping reduce SIDS deaths among infants in the state. Activities related to this performance measure will impact infant mortality related to SIDS in the state.

SPM 5: Percent of pregnancies which are unintended (mistimed or unwanted) and result in live birth or abortion.
Unintended pregnancies are associated with maternal health risk behaviors, low use of preventive health measures including early prenatal care, child abuse, and dependency on welfare. There is a greater risk for complications and poor pregnancy outcomes including infant mortality, birth defects and low birthweight infants.

SPM 7: Percent of high school youth who self-report tobacco use in the past 30 days.
Smoking is responsible for one in six adult deaths in the United States and is the single most preventable cause of death. According to the 2003 YRBS, 60% of respondents have tried cigarette smoking with 18% of respondents having smoked a whole cigarette prior to age 13. Thirty percent of respondents smoked a cigarette during the past 30 days and 62% who have smoked during the past 12 months reported they have tried to quit smoking. Fifteen percent of respondents had used chewing tobacco or snuff during the past 30 days.

SPM 9: Percent of school-aged children and adolescents who are overweight or obese.
Obesity is a risk factor for many chronic medical conditions including cardiovascular disease, hypertension, diabetes, degenerative joint disease, and psychological problems. Overweight can result from excessive energy intake, decrease energy expenditure or impaired regulation of energy metabolism. Activities include development of a system to assess and monitor obesity in school-aged children.

SPM 11: Percent of children age 2-5 who are overweight or obese.
Obesity is a risk factor for many chronic medical conditions including cardiovascular disease, hypertension, diabetes, degenerative joint disease, and psychological problems. Overweight can result from excessive energy intake, decrease energy expenditure or impaired regulation of energy metabolism. Weight-for-height during early infancy predicts weight-for-height during late infancy and childhood.

SPM 12: Percent of infants who are breastfed at least 6 months.
Breastfeeding provides the most complete nutrition for infants and has many benefits to both mother and infant including decreased new cases and severity of diarrhea, respiratory infections, and ear infections. Infants who are breastfed have less overweight and the overweight is improved the longer the infant is breastfed.

C. NATIONAL PERFORMANCE MEASURES

Performance Measure 01: *The percent of newborns who are screened and confirmed with condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) who receive appropriate follow up as defined by their State.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	5	6	6	5	5
Denominator	5	6	6	5	5
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	100	100	100	100	100

Notes - 2002

Numerator and denominator are 3 year running averages. South Dakota law mandates that all confirmed positive screens must receive appropriate follow-up.

Notes - 2003

Numerator and denominator are 3 year running averages. South Dakota law mandates that all confirmed positive screens must receive appropriate follow-up.

Notes - 2004

Numerator and denominator are 3-year averages. Includes only resident confirmed cases. South Dakota law mandates that all confirmed positive screens must receive appropriate follow-up.

a. Last Year's Accomplishments

Partnered with Sioux Valley Clinical Laboratories (SVCL) for the provision of newborn metabolic screening laboratory services in South Dakota for mandated disorders and optional screening under the Newborn Metabolic Screening Program.

Updated information links and resources on the DOH Newborn Metabolic Screening website.

Conducted ongoing site visits and phone contacts with hospitals and physician offices offering technical assistance regarding newborn metabolic screening.

Collaborated with SVCL to provide follow-up on infants with indeterminate or abnormal specimens.

Provided follow-up to those infants without metabolic screening results through ongoing matching of birth certificates and lab reports.

Conducted follow-up with the facility of birth or physician on infants with pending screens.

Referred infants diagnosed with a metabolic disorder to CSHS to be referred and followed by the pediatric endocrinologist, dietitian, social worker, and nursing staff.

Utilized the Electronic Vital Records and Screening System (EVRSS) for data collection and monitoring.

Developed provider/parent educational materials regarding hemoglobinopathy screening.

Partnered with SVCL to provide mechanism for optional screening, the supplemental screening (Supp NBS), and hemoglobinopathy screening upon physician order.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Maintain/improve newborn metabolic screening data collection system.				X
2. Screen/provide necessary follow-up for required disorders (i.e., congenital hypothyroidism, galactosemia, PKU, biotinedase deficiencies, congenital adrenal hyperplasia, hemoglobinopathies, amino acid disorders, fatty acid oxidation disorders, and oxi			X	
3. Verify notification of indeterminate and abnormal test results through "Lab Alert" report.				X
4. Provide optional screening for cystic fibrosis.			X	
5. Distribute newborn metabolic screening program brochure to health care providers.			X	
6. Maintain and update newborn metabolic screening program website.				X
7. Link birth/death certificates with newborn metabolic screening program through EVRSS.				X
8. Update program manual as necessary and distribute to hospitals and clinics in the state.				X
9. Refer infants diagnosed with a metabolic disorder to CSHCN program.		X		
10. Conduct site visits as needed with birthing facilities and laboratories to provide technical assistance with screening process.				X

b. Current Activities

Making improvements to the newborn metabolic screening data collection system and internal protocols to improve effectiveness in identifying babies that need further testing and follow-up.

Screening infants for congenital hypothyroidism, galactosemia, and phenylketonuria (PKU), and identify infants needing follow-up for indeterminate, abnormal, or never tested results.

Performing quality assurance activities to verify notification of indeterminate and abnormal test results.

Providing optional screening for hemoglobinopathy disorders and Supplemental (optional) screening via an arrangement with the state designated laboratory, Baylor University and the New England Newborn Screening Program to detect metabolic disorders through tandem mass

spectrometry.

Distributing brochure explaining the Newborn Metabolic Screening Program to hospitals, physician, and other health care providers in the state.

Maintaining and updating the website, including links to SVCL, Baylor University Medical Center's Supplemental Screening web page, and other resources to allow families and clinicians to easily obtain information on metabolic screening.

Collaborating with the department's Vital Records and Statistics Program to link birth and death certificates with the Newborn Metabolic Screening Program through the Electronic Vital Records Screening System (EVRSS).

Updating as needed the Newborn Metabolic Screening Program manual and distribute to all hospitals and clinics in the state.

Ongoing referral of infants diagnosed with a metabolic disorder to CSHCN Program for follow-up care coordination and treatment.

Monitoring participation percentage of Supp NBS optional screening with the mandated disorders.

Conducting site visits as needed to birthing facilities and laboratories to provide technical assistance with screening process.

Updating administrative rules to require additional mandated screening for biotinidase deficiencies, congenital adrenal hyperplasia, hemoglobinopathies, amino acid disorders, fatty acid oxidation disorders, and organic acid disorders.

Providing optional screening for cystic fibrosis.

c. Plan for the Coming Year

Screen all infants born in South Dakota for inheritable disease/metabolic disorders as required by law. Collaborate with health care providers, hospitals and SVCL to make information available as needed to parents/guardians of newborns regarding the necessity and benefits of screening. Compare submitted laboratory reports with the birth records and follow-up with hospital of birth or physician of infants who do not have testing completed or have abnormal results.

Refer newborn infants identified with positive screening results for follow-up testing and any needed medical treatment. Implement, review and update protocols for follow-up on abnormal test results.

Evaluate and enhance, as necessary, data collection methods in order to meet reporting requirements.

Monitor participation of optional testing for cystic fibrosis and evaluate the appropriateness of adding disorders to the screening program.

Prepare educational materials for parents/providers regarding the additional mandated metabolic disorders, the Newborn Metabolic Screening program, mandated testing, and optional screening for cystic fibrosis.

Provide ongoing evaluation of the Metabolic Newborn Screening program.

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective				59.5	60
Annual Indicator			59.5	59.5	94.3
Numerator					840
Denominator					891
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	95	95	95	95	95

Notes - 2002

The 2002 indicator is based on the State estimates from SLAITS.

Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure. Data not available for years prior to 2002.

Notes - 2004

2004/2005 South Dakota CSHCN survey

a. Last Year's Accomplishments

Worked with South Dakota Parent Connection to promote family involvement in the care of CSHCN, maintain a database of mentor parents and provide parent education and sibling of CSHCN workshops.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Collaborate with SD Parent Connection on activities to support parents in decision making.		X		
2. Network with parent groups, private sector and others to promote family involvement.				X
3. Seek input from parents of CSHCN through a variety of avenues.		X		

4. Provide financial support for parent training and support activities.		X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Collaborating with South Dakota Parent Connection regarding parent training opportunities, parent mentors, FILE record system, and other activities to support parents in decision making.

Networking with parent groups, private sector and other agencies and programs to promote family involvement in their CSHCN's care.

Seeking input from parents of CSHCN via discussions at clinic visits, home visits, child and family intake and assessment, and networking activities.

Through arrangement with SD Parent Connection, providing financial support (including technical assistance, reimbursement for travel and child care costs) for parent training and support activities.

c. Plan for the Coming Year

Collaborate with SD Parent Connection, Center for Disabilities, Children's Care Hospital and School, and other entities on projects to assist families of CSHCN, including but not limited to, a record keeping FILE system for families, development and use of fact sheets about various programs and conditions, and training opportunities for providers and parents.

Collaborate with SD Parent Connection to: (1) identify and recruit parents of CSHSN for the provision of peer support and mentoring; (2) provide a family perspective to CSHS staff; (3) maintain statewide database of support parents, groups and programs within the state and provision of this information to parents; and (4) provide parent-to-parent training and support.

Collaborate with South Dakota Parent Connection on surveys and discussion groups to gather information from parents regarding National Performance Measures.

Identify family members of CSHSN to utilize for staff inservice and other trainings of professionals serving CSHCN and their families.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual					

Performance Objective				54.7	55
Annual Indicator			54.7	54.7	83.0
Numerator					567
Denominator					683
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	84	85	85	85	85

Notes - 2002

The 2002 indicator is based on the State estimates from SLAITS.

Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure. Data not available for years prior to 2002.

Notes - 2004

2004/2005 South Dakota CSHCN Survey

a. Last Year's Accomplishments

Provided care coordination, clinical services and/or financial assistance to children with chronic medical conditions and disabling illness and their families through CSHS.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	**ES**	**PBS**	**IB**
1. Conduct diagnostic and consultative specialty clinics at the CSHS regional office sites.			**X**	
2. Provide care coordination services to children with chronic medical conditions/disability illness.		**X**		
3. Partner with state Medicaid program to provide high-level care coordination of CSHCN.				**X**
4. Maintain ongoing relationships with physicians to facilitate coordination of care for CSHCN.		**X**		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Conducting diagnostic and consultative specialty outreach clinics at the CSHS regional office sites. CSHCN clients not eligible for financial assistance are also seen in specialty clinics and

either the child's family and/or appropriate third party payer are billed.

Providing care coordination services to children with chronic medical conditions and disabling illness. CSHS utilizes a multi-disciplinary team consisting of pediatric subspecialists, nurses, social workers, and dietitians to work with the primary care physician in the provision of care coordination and follow-up for CSHCN and their families. All children served through CSHS are required to identify a physician/health care provider who accepts responsibility for their primary care. Staff assist in the linkage with a medical home if one does not exist.

Partnering with the state Medicaid program in the provision of high-level care coordination of CSHCN, thus allowing for exemption from Medicaid Managed Care.

Maintaining ongoing relationships with physicians through networking activities and follow-up care of individual children to facilitate coordination of care for CSHCN.

c. Plan for the Coming Year

Collaborate with medical providers, ORH, SDAHO, SDSMA, CHAD, and Academies of Pediatrics and Family Practice to promote medical home and family-centered, community-based care for CSHCN.

Collaborate with the Center for Disabilities, Parent Connection, Family Support, and other entities regarding awareness of the importance of a medical home for CSHCN.

Collaborate with South Dakota Parent Connection on surveys and discussion groups to gather information from parents regarding National Performance Measures.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective				60.8	61
Annual Indicator			60.8	60.8	77.5
Numerator					707
Denominator					912
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	78	78	79	79	79

Notes - 2002

The 2002 indicator is based on the State estimates from SLAITS.

Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure. Data not available for years prior to 2002.

Notes - 2004

2004/2005 South Dakota CSHCN Survey

a. Last Year's Accomplishments

Assisted in the identification and referral of numerous CSHCN and their families and facilitated their application to Medicaid, SCHIP and SSI.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide financial assistance on a cost share basis for services for CSHCN.	X			
2. Assist in identification and referral of CSHCN to Medicaid, CHIP and SSI.		X		
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Providing financial assistance on a cost share basis according to family size and income for physician visits, hospitalizations, prescription medications, laboratory testing, radiology testing/procedures, and inpatient and outpatient treatment relative to specified conditions and procedures.

Assisting in the identification and referral of numerous CSHCN and their families and facilitate their applications to Medicaid, SCHIP and SSI.

Linking families to other resources that can assist families "fill the gaps" if there are needs not being met by their public or private health care coverage.

c. Plan for the Coming Year

Revise and update the Joint Powers Agreement with DHS, SSA and DOH to facilitate action on transmittals from Disability Determination Services.

Collaborate with DHS (Divisions of Mental Health, Developmental Disabilities, and Vocational Rehabilitation), SSA, DSS (Medicaid and SCHIP), and DOE (Birth to 3) to assist in the provision of coverage and services for CSHCN.

Develop and maintain ongoing communication with the major insurance carriers in the state, initiate provider agreements as appropriate, and facilitate understanding of the needs of CSHCN.

Collaborate with South Dakota Parent Connection on surveys and discussion groups to gather information from parents regarding National Performance Measures.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective				75.4	75.4
Annual Indicator			75.4	75.4	69.6
Numerator					595
Denominator					855
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	76	76	76	76	76

Notes - 2002

The 2002 indicator is based on the State estimates from SLAITS.

Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure. Data not available for years prior to 2002.

Notes - 2004

2004/2005 South Dakota CSHCN Survey

a. Last Year's Accomplishments

Received referrals during the fiscal year from physicians, schools, parents, hospitals, and other agencies.

Assisted in the provision needed services for specialty care and/or primary care follow-up for CSHCN during the fiscal year in their home community.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

	Pyramid Level of

Activities	Service			
	DHC	ES	PBS	IB
1. Formalize identification/referral process and improve coordination of care for CSHCN.				X
2. Provide pediatric specialty outreach and telemedicine clinics at three regional sites.			X	
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Continuing to formalize identification and referral process and improve coordination of care for CSHCN through linkages with other agencies, programs and providers.

Providing pediatric specialty outreach and telemedicine clinics at Aberdeen, Pierre and Rapid City regional offices.

c. Plan for the Coming Year

Network and coordinate with local medical and related service providers to facilitate early identification and referral of CSHCN.

Collaborate with South Dakota Parent Connection on surveys and discussion groups to gather information from parents regarding National Performance Measures.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective				5.8	6
Annual Indicator			5.8	5.8	49.6
Numerator					211
Denominator					425
Is the Data Provisional or				Final	Final

Final?					
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	50	50	55	55	55

Notes - 2002

Because only one of the States (Maine) met the NCHS standards for reliability for PM 6, the 2002 indicator is the national average except for Maine which has its State value noted.

Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure. Data not available for years prior to 2002.

Notes - 2004

2004/2005 South Dakota CSHCN Survey

a. Last Year's Accomplishments

Assisted youth and families with transition to adult services in conjunction with care coordination activities.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	**ES**	**PBS**	**IB**
1. Assist adolescent CSHCN identify/address needs related to transition to adult life.		**X**		
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Assisting adolescent CSHCN and their families in identifying and addressing their needs related to transition to all aspects of adult life through care coordination activities.

c. Plan for the Coming Year

Provide additional training to CSHS staff regarding the issues related to transition to adult care and the services available.

Collaborate with South Dakota Parent Connection on surveys and discussion groups to gather information from parents regarding National Performance Measures.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	81.5	83	84.5	82	83
Annual Indicator	78.6	77.9	79.8	80.5	80.3
Numerator	8193	8003	8205	8266	8390
Denominator	10423	10272	10282	10265	10448
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	84	85	86	86	88

a. Last Year's Accomplishments

Served as a "selectively" universal vaccine provider. Distributed diphtheria, tetanus, acellular pertussis, Haemophilus influenza B, measles, mumps, rubella, polio, and hepatitis B vaccines for children 18 years of age and younger and varicella to children 12-24 months and children entering kindergarten. Prevnar was made available to all age-appropriate VFC-eligible children.

Maintained the South Dakota Immunization Information System (SDIIS). There are currently 248 public and private providers using SDIIS in 66 counties in South Dakota with approximately 412,368 records and over 3.2 million individual immunizations.

Partnered with DSS to assess the immunization status of children receiving public assistance through TANF and Medicaid and immunized those who were due/overdue for vaccinations.

Maintained the WIC/Immunization Program linkage to improve the assessment and administration referral for immunizations for any infant/child seeking services through OCHS/PHA offices.

Recognized providers who achieved the 90% immunization goal at the 2004 Awards of Excellence luncheon. Fourteen clinics (with more than 50 clients age 19-35 month) received the "Golden Syringe Award" for reaching and consistently maintaining a 90% immunization coverage goal for 2 year olds. The largest clinic in the state received the "Silver Syringe Award" for having the most improved immunization rate. Fifty four clinics (with 50 or fewer clients aged 19-35 months) received certificates for consistently maintaining immunization coverage rates at 90% or higher for 19-35 month olds.

Completed audits of immunization records to assure appropriate immunization levels of children in Day Care/Head Start centers which found that 95% of day care clients and 93% of Head Start clients were age-appropriately immunized.

Completed assessments of immunization records for all kindergarten and transfer students in South Dakota schools to assure compliance with state immunization requirements for school entry which found that 97.4% had the immunizations required by law to enter school.

Provided technical assistance and resources to 10 local community immunization coalitions which educate the community and sponsor activities to increase age-appropriate immunization.

Conducted a retrospective immunization survey of all two year olds by county and found 81% of children were age-appropriately immunized. This is the highest vaccination rate since the tracking began and has increased from 62% since 1994.

Provided vaccine education to physicians, nurses, and other health care professionals regarding childhood immunizations.

Maintained the federal Vaccines for Children (VFC) program to ensure that children who are Medicaid-enrolled, Native American, uninsured, and underinsured received immunizations in a timely manner.

Promoted influenza vaccination for high-risk children of all ages and healthy children aged 6 to 23 months.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Purchase varicella vaccine.			X	
2. Utilize local field staff to serve on local community immunization workgroups.			X	
3. Continue as a "selectively" universal vaccine provider and distribute federally-funded vaccine.			X	
4. Distribute immunization materials to health care providers and other interested organizations.			X	
5. Collaborate with DSS to assess immunization status of children receiving public assistance.			X	
6. Assure access to immunizations for infants/children receiving Bright Start home visits		X		
7. Add a "Parent's Guide to Childhood Immunization" to the Bright Start Welcome boxes.			X	
8. Refine local agency plan to improve assessment, administration and referral for immunizations.			X	
9. Review immunization PSAs to educate on the importance of childhood immunizations.			X	
10. Promote childhood immunizations.			X	

b. Current Activities

Utilizing state funds to purchase varicella vaccine to support the state's childhood varicella immunization initiative.

Utilizing local field staff to serve on local community immunization workgroups to assess

immunization needs and facilitate development of plans to immunize children.

Continuing as a "selectively" universal vaccine provider and distribute federally-funded vaccine free of charge through ODP. Special arrangements are made for receipt of varicella and Prevnar based upon insurance status. Utilizing OCHS/PHA nurses to administer vaccine and coordinate numerous activities to raise public awareness about the importance of immunizations.

Converting the current SDIIS to a web-enabled system that will be more user-friendly.

Distributing immunization materials to hospitals, clinics, DOH field offices, day cares, schools, Head Starts, and other interested organizations.

Collaborating with DSS to assess immunization status of children receiving public assistance through TANF and in the general Medicaid population of children under age two.

Assuring access to immunizations for infants and children receiving home visits through Bright Start.

Collaborating with DSS Office of Child Care Services to add a "Parent Guide to Childhood Immunization" to the Bright Start Welcome Boxes that are sent to new parents.

Continuing to develop and refine local agency plan to improve the assessment, administration and referral for immunizations. The local plan focuses on the WIC/immunization linkage and any infant/child seeking services through OCHS/PHA offices.

Reviewing immunization PSAs to air on radio and television to educate families on the importance of having their child immunized.

Collaborating with the Immunization Program to promote childhood immunizations in the state.

Providing technical assistance and resources to 10 local immunization coalitions.

Conducting annual retrospective survey of two-year olds as well as annual audits of immunization records for all kindergarten and transfer students, licensed day care centers, and Head Starts.

Collaborating with Delta Dental, SDDA, and the DOH Oral Health program to assess the immunization status of children receiving services through the South Dakota Dental Care Mobile and providing those immunizations that are necessary to bring children up-to-date (excluding varicella).

c. Plan for the Coming Year

Utilize state funds to purchase varicella vaccine to support the state's childhood varicella immunization initiative.

Serve on local community immunization workgroups to assess immunization needs and facilitate development of plans to immunize children.

Continue as a "selectively" universal vaccine provider and distribute federally-funded vaccine free of charge through ODP. Special arrangements will be made for receipt of varicella, Prevnar and Menatra based upon insurance status.

Distribute immunization materials to hospitals, clinics, DOH field offices, day cares, schools,

Head Starts, and other interested organizations.

Collaborate with DSS to assess the immunization status of children receiving public assistance through TANF and in the general Medicaid population of children under age two.

Assure access to immunizations for infants and children receiving home visits through Bright Start.

Continue to develop and refine local agency plan to improve assessment, administration and referral for immunizations. The local plan focuses on the WIC/immunization linkage and any infant/child seeking services through OCHS/PHA offices.

Collaborate with DSS to add "Parents Guide to Childhood Immunization" to the Bright Start Welcome Boxes that are sent to new parents.

Review immunization public services announcements to air on radio and television to educate families of the importance of having their child immunized.

Provide technical assistance and resources to 10 local immunization coalitions.

Conduct annual retrospective survey of two-year olds as well as annual audits of immunization records for all kindergarten and transfer students, licensed day care centers, and Head Starts.

Collaborate with Delta Dental, SDDA, and the DOH Oral Health program to assess the immunization status of children receiving services through the South Dakota Dental Care Mobile and provide those immunizations that are necessary to bring children up-to-date (excluding varicella).

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	23.5	23.5	16	16	16
Annual Indicator	19.4	18.3	17.5	17.4	17.4
Numerator	355	336	309	303	299
Denominator	18326	18326	17673	17409	17165
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	15	15	14	14	13

Notes - 2002

1998 and 1999 denominator are 1990 Census data. 2000 through 2002 denominators are 2000 Census data.

Notes - 2003

1998 and 1999 denominator are 1990 Census data. 2000 through 2003 denominators are 2000 Census data.

a. Last Year's Accomplishments

Funded seven abstinence education projects. Two projects targeted middle and high schools to provide abstinence education to youth and five programs provided youth development-based programming to young girls in after-school programs.

Updated the abstinence page on the DOH website (www.state.sd.us/doh) to provide abstinence education information.

Provided family planning services to 4,357 adolescents age 19 and under during CY04. Of those, 207 were adolescent males (age 19 and younger). Forty-three percent of adolescents seen were 17 years of age or younger.

Provided community/school education services related to reproductive health to 10,530 adolescents in CY04.

Partnered with the Winner community and the Tripp County Public Health Alliance to provide a program for girls in middle school. During the 2002-2003 school year, between 42 and 50 girls attended each monthly sessions.

Collaborated with the Title X Family Planning project for Male Involvement and Research Development in partnership with Boys & Girls Clubs of SD. SMART Moves curriculum was used by seven clubs.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Negotiate new/monitor existing contracts for provision of abstinence education.				X
2. Collaborate with Family Planning program on services to adolescents.			X	
3. Provide community/school education programs related to reproductive health as requested.			X	
4. Monitor new partnerships with Boys & Girls Club of South Dakota to conduct Male Involvement & Research Development Program.			X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Negotiating new and monitoring seven existing contracts with organizations serving youth to provide abstinence education across the state.

Continuing to collaborate with the Title X Family Planning Program on services to adolescents including counseling, education, medical exams, STD screening, and contraceptive supplies.

Providing community/school education programs related to reproductive health to adolescents and parents as requested.

Collaborating on a new partnership with the Boys and Girls Club of South Dakota through special funding from Region VIII Title X Family Planning Office to conduct a Male Involvement and Research Development Project.

c. Plan for the Coming Year

Collaborate with the Title X Family Planning Program to provide family planning services to adolescents including counseling, education, medical exams, STD screening, and contraceptive supplies.

Provide community/school education programs related to reproductive health to adolescents and parents.

Collaborate with the Department of Corrections to assure juveniles under their supervision are provided education and services necessary to prevent unintended pregnancy.

Provide youth development information and materials that discuss the importance of increasing the protective factors among youth and their relationship to decreasing risk factors among youth to all abstinence grantees.

Provide technical assistance as requested to address teen pregnancy and its related risk factors.

Participate as members of the Department of Education Comprehensive School Health State Advisory Committee and Interagency Workgroup. The committee is comprised of individuals representing schools and organizations through the state that work with school age children and youth.

Support an abstinence education project through five new contracts for funding to local youth serving organizations across the state to increase, enhance and improve abstinence education.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	43.9	43.9	43.9	50	50
Annual Indicator	43.9	43.9	43.9	49.4	49.4
Numerator	4430	4430	4430	351	351

Denominator	10091	10091	10091	710	710
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	50	55	55	55	55

Notes - 2002

Source: 95-97 oral health needs assessment survey data

Notes - 2003

Source (1999-2002): 95-97 oral health needs assessment survey data.
Source (2003): 2002-2003 oral health survey data.

a. Last Year's Accomplishments

Partnered with the State Library to prepare a list of children's dental books to promote NCDHM.

Partnered with WIC and the DSS ECE program to distribute 7,000 infant toothbrushes/gum massagers along with educational materials about the importance of early oral health care.

Provided "train the trainer" oral health education to 30 Head Start and Early Head Start staff as well as the DOH regional managers and 90 CHNs.

Supported the Outreach Dental Clinic in Watertown which utilizes University of Minnesota dental students to provide dental services to individuals without a dental home.

Updated the DOH oral health webpage as needed.

Partnered with the Office of Rural Health to conduct two community dental needs assessments for the Dental Tuition Reimbursement Program.

Visited local elementary schools during NCDHM.

Finalized and distributed the South Dakota Oral Health Survey Report 2002-2003.

Served on the advisory board for the South Dakota Ronald McDonald Delta Dental Care Mobile. The care mobile is a 40-foot mobile dental clinic that will provide dental care to underserved children across the state. The DOH is financially supporting Care Mobile staff and coordinating and evaluating oral health educational materials to be distributed to patients.

Collaborated with the Tobacco Control Program to reduce spit tobacco use.

Participated in health fairs for fifth grade students to provide oral health supplies and educational brochures.

Utilized the oral health informational booth at various events, conferences, health fairs, etc.

Served on the advisory board for the Medical/Dental Interfaces project.

Provided educational materials and resources for the ABCD training.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide "train the trainer" oral health education to Head Start/Early Head Start staff and DOH regional managers and CHNs.				X
2. Support Outreach Dental Clinic in Watertown which utilizes University of Minnesota dental students to provide services to individuals without a dental home.			X	
3. Update the DOH oral health webpage as needed.				X
4. Partner with the DOH Office of Rural Health to conduct community dental needs assessments for the Dental Tuition Reimbursement Program.				X
5. Serve on the advisory board for the South Dakota Ronald McDonald Delta Dental Care Mobile.				X
6. Collaborate with the Tobacco Control Program to reduce spit tobacco use.			X	
7. Participate in health fairs for 5th grade students to provide oral health supplies and educational materials.			X	
8. Utilize the oral health informational booth at various events, conferences, health fairs, etc.			X	
9.				
10.				

b. Current Activities

Participating on the Oral Health Coalition steering committee which addresses the following priorities -- Education/Prevention, Work Force Development, and Access to Care. The DOH chairs the Education/Prevention workgroup.

Facilitating oral health discussions and planning with partners including SDDA, Delta Dental, Medicaid, Head Start, Office of Rural Health, CHAD, IHS, WIC, and other health professionals regarding options for improving access to oral health care for underserved children in South Dakota.

Facilitating education/training opportunities to update DOH field staff in offices throughout the state (including WIC), community health centers staff, Head Start staff, day care providers, and other health providers on oral health issues.

Working with SDDA to distribute information to dental and medical professionals about encouraging achievement of oral health-related performance measures, HP 2010 and collection of data to measure progress towards these objectives.

Continuing discussions with Medicaid, Delta Dental, SDDA, and Office of Rural Health regarding options for improving access to oral health care for children in South Dakota.

Collaborating with the Tobacco Control Program to reduce spit tobacco use.

Partnering with Delta Dental on the Care Mobile project to provide educational materials and resources to underserved children.

c. Plan for the Coming Year

Participate on the Oral Health Coalition steering committee which addresses the following priorities -- Education/Prevention, Work Force Development, and Access to Care. The DOH chairs the Education/Prevention workgroup.

Facilitate oral health discussions and planning with partners including SDDA, Delta Dental, Medicaid, Head Start, Office of Rural Health, CHAD, IHS, WIC, and other health professionals regarding options for improving access to oral health care for underserved children in South Dakota.

Facilitate education/training opportunities to update DOH field staff in offices throughout the state (including WIC), community health centers staff, Head Start staff, day care providers, and other health providers on oral health issues.

Work with SDDA to distribute information to dental and medical professionals about encouraging achievement of oral health-related performance measures, HP 2010 and collection of data to measure progress towards these objectives.

Continue discussions with Medicaid, Delta Dental, SDDA, and Office of Rural Health regarding options for improving access to oral health care for children in South Dakota.

Collaborate with the Tobacco Control Program to reduce spit tobacco use.

Partner with Delta Dental on the Care Mobile project to provide services to underserved children.

Conduct Basic Screening Survey of 3rd grade students.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2000**	**2001**	**2002**	**2003**	**2004**
Annual Performance Objective	6.4	6.2	10.5	10	9.5
Annual Indicator	9.6	10.2	11.1	11.3	11.3
Numerator	16	17	18	18	18
Denominator	167497	166257	162077	159813	159813
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	10	10	9.5	9.5	9.5

Notes - 2002

1998 and 1999 denominator are 1990 Census data. 2000 through 2002 denominators are 2000 Census data. Numerator and denominator are 3 year running averages.

Notes - 2003

1998 and 1999 denominator are 1990 Census data. 2000 through 2003 denominators are 2000 Census data. Numerator and denominator are 3 year running averages.

Notes - 2004

Numerator and denominator are 3-year averages. Denominator is Census Population Estimates.

a. Last Year's Accomplishments

Collaborated with the Office of Highway Safety (OHS) to support special needs child safety seats in South Dakota.

Coordinated with regional CSHS offices to distribute special needs car seat to children whose medical conditions require special seating for safety purposes.

Provided technical assistance on child passenger safety seats and booster seats to local DOH staff, schools and communities.

Collaborated with OHS to promote National Child Passenger Safety Week (NCPSW) by distributing information materials to over 1,500 contacts in the state as well as dissemination of a public service annoucement. The theme of NCPSW was to encourage the four steps of child passenger safety -- infant rear-facing, forward facing, booster seat and seatbelts.

Collaborated with OHS on child passenger check points and shared this information with local CHN offices in the state.

Continued to collaborate with OHS and other partners to educate the public on the primary child restraint law for children and youth 18 years of age and under and the importance of using booster seats for children aged 4-8.

Continued to encourage CHS staff to discuss child passenger safety and seatbelt information with parents during well child assessments, home visits, prenatal classes, and health education classes.

Represented the DOH on the OHS Roadway Committee.

Maintained the injury web page on the DOH website (www.state.sd.us/doh).

Participated on the Roadway Safety Committee in the development and implementation of the "Office of Highway Safety Plan for South Dakota".

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Participate on the Roadway Safety Committee in the development/implementation of the "Office of Highway Safety Plan for South Dakota".				X
2. Collaborate with the Office of Highway Safety on child passenger			X	

check points.				
3. Distribute special needs child safety seats to children with certain medical conditions.		X		
4. Provide materials to CHS staff to discuss child passenger safety with parents during visits/classes.			X	
5. Collaborate with partners on activities related to injury prevention.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Collaborating with OHS on child passenger safety/check points and sharing this information on with local CHN offices.

Providing information to CHS staff to discuss child passenger safety and seat belt information with parents during well child assessments, home visits, prenatal classes, and health education classes.

Collaborating with OHS and Roadway Safety Committee to implement the Safety Plan for South Dakota.

c. Plan for the Coming Year

Participate on the Roadway Safety Committee in the development and implementation of the "Office of Highway Safety Plan for South Dakota".

Collaborate with OHS on child passenger safety/check points and share this information on with local CHN offices.

Provide information to CHS staff to discuss child passenger safety and seat belt information with parents during well child assessments, home visits, prenatal classes, and health education classes.

Transfer all car seat information and car seat distribution activities to OHS.

Performance Measure 11: *Percentage of mothers who breastfeed their infants at hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	63	64	68	68	68

Annual Indicator	65.6	67.2	67.4	67.5	68.7
Numerator	6945	7202	7392	7741	8090
Denominator	10589	10717	10963	11460	11773
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	69	70	70	71	71

a. Last Year's Accomplishments

Collected breastfeeding initiation rates for the state and by individual hospital via the Newborn Screening Program. Sent letters to hospitals with their individual rates and materials on how to increase and support breastfeeding.

Loaned 175 electric breast pumps to MCH and WIC clientele to encourage continued breastfeeding. WIC also provided program participants with manual breast pumps as needed.

Served as an active member of the Breastfeeding Coalition which is made up of lactation consultants, USD School of Medicine, Cooperative Extension Services, and other interested parties. Collaborated with the Breastfeeding Coalition to promote World Breastfeeding Week's theme "Exclusive Breastfeeding -- The Gold Standard: Safe, Sound, Sustainable". Obtained a Governor's proclamation for World Breastfeeding Week.

Educated mothers in the Bright Start home visiting, WIC, and perinatal programs on the benefits of breastfeeding and providing support and encouragement to initiate breastfeeding.

Set up Breastfeeding Coalition's display at the SDSU Nutrition Seminar.

Developed a breastfeeding self study module for Community Health Services clerical staff to provide them with education on how to provide breastfeeding support to mothers.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	**ES**	**PBS**	**IB**
1. Collect breastfeeding initiation rates for the state and by individual hospitals.			**X**	
2. Provide electric breast pumps to MCH/WIC clientele to encourage continued breastfeeding.			**X**	
3. Serve as active member of the Breastfeeding Coalition.				**X**
4. Educate mothers in various DOH programs of the benefits of breastfeeding and provide support/encouragement to initiate and continue breastfeeding.			**X**	
5. Provide and update breastfeeding information on the DOH website and Healthysd.gov.			**X**	
6. Partner with CDC nutrition and physical activity programs to provide resources to educators of prenatal and breastfeeding classes and to				**X**

develop and implement a statewide plan to improve breastfeeding rates.				
7.				
8.				
9.				
10.				

b. Current Activities

Continued to collect breastfeeding initiation rates for the state and by individual hospital via the Newborn Screening Program. Send letters to hospitals with their individual rates and materials on how to increase and support breastfeeding.

Provided 241 electric breast pumps to MCH and WIC clientele to encourage continued breastfeeding. WIC also provided program participants with manual breast pumps as needed.

Served as an active member of the Breastfeeding Coalition which is made up of lactation consultants, USD School of Medicine, Cooperative Extension Services, and other interested parties. Collaborated with the Breastfeeding Coalition to promote World Breastfeeding Week with the theme of "Breastfeeding and Family Foods: Loving and Healthy". Obtained a Governor's proclamation for World Breastfeeding Week.

Educated mothers in the Bright Start home visiting, WIC, and perinatal programs on the benefits of breastfeeding and providing support and encouragement to initiate breastfeeding.

Revising the Breastfeeding Self-Study Packet that is used to provide initial and ongoing training to DOH staff who provide breastfeeding counseling. The packet also includes information for support staff to enable them to promote breastfeeding and create a positive breastfeeding environment.

Identified a breastfeeding coordinator for each DOH OCHS office.

Collaborated with CDC Nutrition and Physical Activity Grant to highlight breastfeeding on the Healthysd.gov website and collaborated with the Breastfeeding Coalition and the Grant to develop and print two brochures on returning to work and breastfeeding.

Partner with CDC nutrition and physical activity programs to start development a statewide plan to improve breastfeeding initiation rates.

Co-sponsored SDSU Nutrition Seminar which included speakers on breastfeeding. Over 150 were in attendance.

The South Dakota WIC Program was awarded a grant from USDA to implement a Breastfeeding Peer Counselor Program. Breastfeeding Peer Counselors will work with WIC pregnant and breastfeeding women in Beadle, Brookings and Butte- Belle Fourche counties. The Breastfeeding Peer Counselors were trained using the Loving Support through Peer Counseling curriculum. The three Local Agencies have also received training on the Breastfeeding Peer Counselor program and how they can work as a team to educate and support breastfeeding WIC participants.

Local WIC Agency staff were provided training on the Best Start 3 Step Counseling Strategy via DDN. The Best Start 3-Step Counseling Strategy(c) allows the healthcare provider to quickly determine each client's individual barriers to optimal health behavior, and to address those barriers effectively in encouraging positive health choices.

c. Plan for the Coming Year

Continue representation on the South Dakota Breastfeeding Coalition to provide a networking system for breastfeeding education and promotion.

Educate mothers in the Bright Start home visiting, WIC and perinatal programs on the benefits of breastfeeding and provide support and encouragement to initiate and continue breastfeeding.

Enhance partnerships with Medicaid and other health professionals to encourage more women to breastfeed.

Continue to provide and update breastfeeding information on the DOH website and Healthysd.gov.

Collaborate with WIC to develop, purchase and distribute materials for World Breastfeeding Week and for ongoing marketing of breastfeeding.

Collect breastfeeding initiation data via the newborn metabolic screening program. Analyze the data and provide hospitals with breastfeeding initiation rate data specific to their facility as well as information on ways to improve breastfeeding rates for their facility.

Set up Breastfeeding Coalition's display at the SDSU Nutrition Seminar.

Partner with CDC nutrition and physical activity programs to provide resources to educators of prenatal and breastfeeding classes and to develop and implement a statewide plan to improve breastfeeding rates.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2000**	**2001**	**2002**	**2003**	**2004**
Annual Performance Objective	75	80	85	90	90
Annual Indicator	65.5	73.2	77.1	83.2	88.0
Numerator	6937	7890	7153	9569	10385
Denominator	10589	10784	9283	11501	11805
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	90	90	90	90	90

Notes - 2002

Final 2002 data is not yet available.

a. Last Year's Accomplishments

Continued to collaborate with hospitals to ensure that all babies born in South Dakota are screened for hearing impairment before the age of 1 month, evaluation from a diagnostic audiologist by three months of age, and intervention by six months of age.

Facilitated periodic meetings of the Advisory Committee on Newborn Hearing Screening, either in person or via DDN.

Continued to make available trainings with hospitals that received state owned hearing screening equipment.

Submitted a successful application to CDC for data management and tracking and implemented the program in Newborn Hearing Screening.

Participated in the Maternal and Child Health Newborn Hearing Screening grant to implement universal newborn hearing screening of infants prior to hospital discharge.

Distributed educational materials regarding causes of infant hearing loss and language and hearing developmental milestones to the appropriate facilities statewide.

Collaborated with the Office of Vital Records in the statewide implementation of the Electronic Vital Records and Screening System (EVRSS) successfully linking birth records with infant metabolic and hearing screening for all infants born in the state. This system allows for tracking of these infants for follow-up, confirmatory testing and treatment. It is linked with the hospitals, physician clinics and audiologists who provide follow-up and diagnostic services to the infants.

Replaced 12 Echoports with more user friendly Audx hearing screening equipment and provided training at each site receiving new equipment.

Bought 40 audiometers for CHNs/school nurses across the state.

Bought and distributed the "Give Your Baby a Sound Beginning" video to audiologists, physicians, birth facilities, and speech therapists. Versions are available in English, Spanish and closed caption.

Updated the EHDI web site.

Abstract presentation on the EVRSS program was awarded for the EHDI conference.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Ensure infants receive timely hearing screening, evaluation and intervention.				X
2. Hold meetings of the Advisory Committee on Newborn Hearing Screening.				X
3. Organize training for facilities with state-owned hearing screening equipment.				X
4. Implement and train facilities on data entry for EVRSS.				X

5. Include Newborn Hearing Screening Program brochure in Bright Start Welcome Box.			X	
6. Update the Newborn Hearing Screening website with current information.				X
7. Present information regarding the Newborn Hearing Screening program to health care providers.				X
8.				
9.				
10.				

b. Current Activities

Continuing to collaborate with facilities to ensure that all babies born in South Dakota are screened for hearing impairment before the age of 1 month, evaluation from a diagnostic audiologist by three months of age, and early intervention by six months of age.

Planning periodic meetings of the Advisory Committee on Newborn Hearing Screening in person and via DDN.

Organizing training with facilities that have received state owned hearing screening equipment.

Implementing/training facilities on data entry into the EVRSS program with rescreening, medical evaluation, and diagnostic audiological results.

Including Newborn Hearing Screening Program brochure into the Bright Start box which is distributed to each baby that is born in South Dakota.

Updating the Newborn Hearing Screening web page with current information.

Conducting ad campaign on the importance of the Newborn Hearing Screening Program.

Presenting EVRSS program at the EHDI conference.

Researching appropriate residential locations of those infants needing screening and placing 12 Audx's in the needed areas and providing training.

c. Plan for the Coming Year

Continue to collaborate with facilities to ensure that all babies born in South Dakota are screened for hearing impairment before the age of 1 month, evaluation from a diagnostic audiologist by three months of age, and early intervention by six months of age.

Monitor the data entry into the EVRSS for the Newborn Hearing Screening Program.

Continue to train and monitor the facilities in the process of the Newborn Hearing Screening program developed by the State of South Dakota.

Facilitate periodic meetings of the Advisory Committee on Newborn Hearing Screening, either in person or via DDN.

Implement and monitor the tracking of infants with possible hearing loss to the Birth to Three programs for early intervention services and funding.

Implement and monitor the tracking of infants with possible hearing loss with their screener,

physician and diagnostic audiologist.

Distribute developed Newborn Hearing Screening materials (in both English and Spanish) to the appropriate sites.

Expand public and patient education efforts to reach those who do not have computer access. Make available appropriate materials that are consistent with what appears on the web page.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	6.3	5.8	5.8	4	4
Annual Indicator	5.9	3.8	3.9	4.3	4.3
Numerator	11709	7701	7701	8309	8309
Denominator	198462	202649	197166	193971	193971
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	4	4	4	4	4

Notes - 2004

Denominator is Census Population Estimates.

a. Last Year's Accomplishments

Collaborated with DSS to assure information regarding CHIP and the expanded non-Medicaid CHIP program was distributed to DOH staff and communities. Communication occurs at numerous levels including upper management-level with the HMS Division Director meeting throughout the year with the Director of the Medicaid Program, meetings with program staff from both agencies, and field staff working together on a daily basis to identify and enroll potential eligibles.

Provided CHIP applications in OCHS/PHA offices and assisted in completion of forms as needed.

Included questions regarding children without health insurance on the 2003 BRFSS. Results indicate that there was a slight increase in the percent of children without health insurance from 3.4 in 2002 to 4.1 in 2003.

Provided links to the DSS Medicaid website from the DOH website.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Assure information regarding CHIP is distributed to DOH staff and communities.				X
2. Provide CHIP applications in DOH field offices and assist in completion of forms as needed.			X	
3. Provide links to the DSS Medicaid website from the DOH website.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Collaborating with DSS to assure information regarding CHIP and the expanded non-Medicaid CHIP program is distributed to DOH staff and communities.

Providing CHIP applications in OCHS/PHA offices and assisting in completion of forms as needed.

Providing links to the DSS Medicaid website from the DOH website.

c. Plan for the Coming Year

Continue collaborative efforts with DSS to assure information regarding CHIP and the expanded non-Medicaid CHIP program was distributed to DOH staff and communities.

Continue to provide CHIP applications in OCHS/PHA offices and assist in completion of forms as needed.

Provide links to the DSS Medicaid website from the DOH website.

Performance Measure 14: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	71.7	72	80	80	81

Annual Indicator	75.0	77.5	80.0	80.0	80.0
Numerator	62673	66768	71631	75034	77151
Denominator	83564	86152	89539	93793	96439
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	81	82	82	83	83

a. Last Year's Accomplishments

Maintained ongoing collaboration with DSS to provide EPSDT services. DSS has administrative responsibility for Medicaid and EPSDT in the state and determination limits of eligibility, coverage of services and methods for reimbursing providers as well as set standards for screening protocols and periodicity with recommendations and comments from the DOH. Staff from DSS and DOH coordinated referral mechanisms at the local level to assure potentially eligible clients were appropriately referred.

Maintained interagency agreement with DSS to assure that Title XIX and Title V services are consistent with the needs of recipients and that objectives and requirements of the program are met.

Provided ongoing education to families regarding primary/preventive care for their children and to assure that children seen in public health agencies have a medical home.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	**ES**	**PBS**	**IB**
1. Provide EPSDT services.		**X**		
2. Assure Title XIX and V services are consistent with needs of recipients.				**X**
3. Provide education to families regarding primary/ preventive care for their children.			**X**	
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Collaborating with DSS to provide EPSDT services. Staff from DSS and DOH are coordinating referral mechanisms at the local level to assure potentially eligible clients are appropriately referred.

Maintaining interagency agreement with DSS to assure that Title XIX and Title V services are

consistent with the needs of recipients and that objectives and requirements of the program are met.

Providing ongoing education to families regarding primary/preventive care for their children and to assure that children seen in public health agencies have a medical home.

c. Plan for the Coming Year

Continue collaboration with DSS to provide EPSDT services. Staff from DSS and DOH will coordinate referral mechanisms at the local level to assure potentially eligible clients are appropriately referred.

Renew interagency agreement with DSS to assure that Title XIX and Title V services are consistent with the needs of recipients and that objectives and requirements of the program are met.

Provide ongoing education to families regarding primary/preventive care for their children and to assure that children seen in public health agencies have a medical home.

Performance Measure 15: *The percent of very low birth weight infants among all live births.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	1	1	1	1	1
Annual Indicator	0.9	1.1	0.9	1.1	1.2
Numerator	98	116	97	122	139
Denominator	10346	10475	10698	11022	11339
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	1	1	1	1	1

a. Last Year's Accomplishments

Participated on March of Dimes Coalition to address issues related to prematurity.

Supported two perinatal health conferences -- the Avera Health Systems Perinatal Conference and SD Perinatal Association Annual Conference.

Included education on warning signs of preterm labor to all Baby Care and Bright Start clients.

Participated on workgroup with DSS Medicaid program to review charts of mothers and infants whose hospitalization resulted in the highest costs to that program.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Identify issues surrounding delivery of very low birth weight infants.			X	
2. Participate on March of Dimes Coalition to address issues related to prematurity.				X
3. Assess/educate pregnant women seen at CHS/PHA sites for risks affecting pregnancy outcomes.			X	
4. Educate pregnant women enrolled in Bright Start/Baby Care on signs of preterm labor.			X	
5. Review documentation to assure that Bright Start/Baby Care charts reflect standards of care and evidence of education related to warning signs of preterm labor.				X
6. Analyze data from Perinatal Provider Survey and 2005 Perinatal Health Risk Assessment survey of new mothers and develop and disseminate findings through a report.			X	
7. Share information gathered from DSS workgroup report with stakeholders.			X	
8.				
9.				
10.				

b. Current Activities

Collaborating with physician and hospital groups to identify issues surrounding delivery of very low birth weight infants.

Participating on March of Dimes Coalition to address issues related to prematurity.

Assessing all pregnant women seen at CHS/PHA sites for risks affecting pregnancy outcomes and provide ongoing education to clients on signs of preterm labor.

Collaborating with the Bright Start and Baby Care programs to educate pregnant women enrolled in the program on signs of preterm labor.

Reviewing documentation to assure that Baby Care and Bright Start charts reflect standards of care and evidence of education related to warning signs of preterm labor.

Disseminating new brochure "Helping Your Baby by Learning About the Warning Signs of Preterm Labor" for use with pregnant clients.

Developing summary of findings from DSS workgroup study and sharing with administrators within DSS and DOH.

Analyzing data and writing report from survey of health care providers to ascertain their perception of the importance of early and regular prenatal care as well as identify barriers that may prevent pregnant women from accessing prenatal care in the first trimester.

Developing website on pregnancy information stressing the importance of early and regular prenatal care as well as providing strategies for reducing risk for preterm birth.

Conducting survey of new mothers to ascertain prenatal and postpartum behaviors including identifying issues that impact birth weight and prematurity (i.e., tobacco used, nutritional status, etc.).

c. Plan for the Coming Year

Collaborate with physician and hospital groups to identify issues surrounding delivery of very low birth weight infants.

Participate on March of Dimes Coalition to address issues related to prematurity.

Assess all pregnant women seen at CHS/PHA sites for risks affecting pregnancy outcomes and provide ongoing education to clients on signs of preterm labor.

Collaborate with the Bright Start and Baby Care programs to educate pregnant women enrolled in the program on signs of preterm labor.

Review documentation practice in Bright Start and Baby Care programs.

Disseminate report from the Prenatal Provider Survey with health care providers throughout the state.

Analyze data from the 2005 Perinatal Health Risk Assessment Survey of new mothers and share with health care providers throughout the state.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	29	28.5	17	16	14
Annual Indicator	23.8	22.2	19.3	17.9	17.9
Numerator	13	13	12	11	11
Denominator	54545	58519	62124	61534	61534
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	17.5	17	17	16.5	16.5

Notes - 2002

Numerator and denominator are 3 year running averages.

Notes - 2003

Numerator and denominator are 3 year running averages.

Notes - 2004

Numerator and denominator are 3-year averages. Denominator is Census Population Estimates.

a. Last Year's Accomplishments

Continued to update suicide prevention resources on the DOH website.

Partnered with the HELP! Line Center to be a suicide prevention resource in South Dakota. Trained 909 gatekeepers through 28 QPR (Question, Persuade & Refer) presentations. Presentations were provided to a variety of groups including: Lower Brule High School students and staff, Multiple Sclerosis Society, Glory House, Southeast Behavioral Health Care staff, Florence High school students, Brandon High School students, Mount Marty College students, Washington High School students, Roosevelt High School students, Juvenile Detention Center students, SD School Nurses Association, SD National Alliance for Mentally Ill, and Lennox High School students. Received 703 calls on the 1-800 talk/crisis lines. Distributed 172 "Surviving After Suicide" packets for family and friends that have experienced the loss of a loved one to suicide.

Partnered with DHS, HELP Line Center and Front Porch Coalition to complete the SD Strategy for Suicide Prevention Plan. The plan addresses suicide prevention, specifically for 14-24 year olds through implementation of early intervention and prevention programs.

Participated on the DHS Division of Mental Health's Child Subcommittee.

Updated the YRBS display for CHS office to provide local awareness of the behaviors of South Dakota adolescents.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Collaborate on development of a state suicide prevention plan.				X
2. Partner with HELP! Line Center and Front Porch Coalition to serve as suicide prevention resource.			X	
3. Develop a speakers bureau to give suicide prevention presentations to target audiences associated with at-risk populations.			X	
4. Assemble/disseminate resource guide of evidence-based suicide risk screening/assessment tools, presentations, materials, referral tools, and protocols.				X
5. Establish/promote 1-800-SUICIDE Hopeline and web-based database.			X	
6. Assess university-level course content related to suicide and CEU offerings in clinical suicide training.				X
7. Develop guidelines for suicide prevention, intervention and postvention policies and practices.				X
8. Identify content, outcomes, funding, and distribution mechanisms for suicide prevention, intervention and postvention.				X
9. Work with South Dakota media to recommend guidelines for news coverage of mental illness, suicidal behavior and effects of suicide.				X

10. Improve collection, analysis and dissemination of useful data on suicide attempts.				X

b. Current Activities

Collaborating with other state agencies and community representatives to develop a state suicide prevention plan.

Partnering with the HELP! Line Center and the Front Porch Coalition to serve as a resource for suicide prevention in South Dakota.

Developing a speakers bureau (including standard protocols and information packets for distribution) to give suicide prevention presentations to target audiences associated with at-risk populations.

Assembling and disseminating a resource guide of evidence-based suicide risk screening and assessment tools, prevention programs, related materials, referral tools, and protocols for use by South Dakota caregivers and providing training on its use.

Establishing and widely promoting the 1-800-SUICIDE Hopeline and web-based database to provide up-to-date information for caregivers about the prevention, intervention and postvention services available in South Dakota.

Assessing university-level course content related to suicide and CEU offerings in clinical suicide training.

Working with the Suicide Prevention Resource Center and other partners to identify content, outcomes, funding, and distribution mechanisms that have been used elsewhere in public information campaigns for suicide prevention, intervention and postevention.

Working with the South Dakota media industry to recommend guidelines for news coverage of mental illness, suicidal behavior and the effects of suicide.

Collaborating with stakeholders to improve collection, analysis and dissemination of useful data on suicide attempts.

c. Plan for the Coming Year

Continued collaboration with other state agencies and stakeholders to update and share suicide prevention activities and strategies.

Collaborate with other state agencies and community representatives to implement the state suicide prevention plan.

Continue to partner with the HELP! Line Center and the Front Porch Coalition to serve as a resource for suicide prevention in South Dakota.

Maintain a speakers' bureau to give suicide prevention presentations to target audiences associated with at-risk populations.

Maintain a resource guide of evidence-based suicide risk screening and assessment tools, prevention programs, related materials, referral tools, and protocols for use by South Dakota caregivers and provide training on its use.

Promote the 1-800-SUICIDE Hopeline and web-based database to provide up-to-date information for caregivers about the prevention, intervention and postvention services available

in South Dakota.

Implement recommended changes to university-level course content related to suicide and CEU offerings in clinical suicide training.

Work with the Suicide Prevention Resource Center and other partners to identify content, outcomes, funding, and distribution mechanisms that have been used elsewhere in public information campaigns for suicide prevention, intervention and postevention.

Collaborate with stakeholders to improve collection, analysis and dissemination of useful data on suicide attempts.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	90	90	90	90	90
Annual Indicator	92.1	84.7	87.6	91.7	89.1
Numerator	82	94	78	110	123
Denominator	89	111	89	120	138
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	90	90	90	91	91

a. Last Year's Accomplishments

Collaborated with DOH Office of Data, Statistics and Vital Records to reassess the number of very low birth weight infants born at locations other than facilities with Level III nurseries. Analysis of the data continue to reveal that there is no discernable pattern of facility utilization indicating that many of these births may have been the result of onset precipitous labor with little or no advance warning.

See activities under NPM #15.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Identify issues surrounding delivery of very low birth weight infants,				

including preterm labor.			X	
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Collaborating with physician and hospital groups, March of Dimes, Perinatal Association, and other MCH partners to identify issues surrounding delivery of very low birth weight infants, including preterm labor.

See activities under NPM #15.

c. Plan for the Coming Year

Collaborate with physician and hospital groups, March of Dimes, Perinatal Association, and other MCH partners to identify issues surrounding delivery of very low birth weight infants, including preterm labor.

See activities under NPM #15.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	84	85	86	86	86
Annual Indicator	78.4	78.1	77.6	78.2	77.6
Numerator	8107	8177	8298	8616	8801
Denominator	10346	10475	10698	11022	11339
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance	78	79	79	80	80

Objective					

a. Last Year's Accomplishments

Continued to evaluate data available through the Perinatal Health Risk Assessment survey to identify why women do not receive early prenatal care. Changes were implemented with the most recent survey to better identify intervention strategies.

See activities under NPM #15.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Educate professionals on importance of early prenatal care.			X	
2. Encourage pregnant clients seen at OCHS/PHS/family planning sites to access early prenatal care.			X	
3. Facilitate access to early/regular prenatal care for pregnant women in DOH programs.			X	
4. Conduct Perinatal Health Risk Assessment survey of new mothers.				X
5. Review Bright Start/Baby Care documentation to assure adherence to standards of care and provision of education.				X
6. Analyze data from 2005 Perinatal Health Risk Assessment survey of new mothers and Perinatal Provider Survey to ascertain perceptions of why pregnant women do not seek early and regular prenatal care.			X	
7.				
8.				
9.				
10.				

b. Current Activities

Collaborating with physician groups to educate professionals who reportedly tell patients who believe they may be pregnant to delay accessing prenatal care until their fourth month (second trimester).

Encouraging all pregnant clients seen at OCHS/PHA and delegate family planning sites to access early and regular prenatal care.

Collaborating with the Bright Start, Baby Care and WIC programs to facilitate access to early and regular prenatal care for pregnant women enrolled in the program.

Conducting Perinatal Health Risk Assessment survey of new mothers to ascertain prenatal and postpartum behaviors including identifying barriers to obtaining early and regular prenatal care.

Analyzing results of 2005 Perinatal Health Risk Assessment survey of new mothers which included questions regarding month prenatal care began.

Reviewing Baby Care and Bright Start documentation to assure adherence to standards of care and provision of education.

Reprinting the "Health Diary" to provide pregnant women with prenatal education and

encourage early and regular prenatal care.

See activities under NPM #15.

c. Plan for the Coming Year

Collaborate with physician groups to educate professionals who reportedly tell patients who believe they may be pregnant to delay accessing prenatal care until their fourth month (second trimester).

Encourage all pregnant clients seen at OCHS/PHA and delegate family planning sites to access early and regular prenatal care.

Collaborate with the Bright Start, Baby Care and WIC programs to facilitate access to early and regular prenatal care for pregnant women enrolled in the program.

Distribute report of the 2005 Perinatal Health Risk Assessment survey of new mothers which included questions regarding month prenatal care began.

Establish workgroup to plan for the 2007 Perinatal Health Risk Assessment survey.

Distribute report of the 2005 prenatal care providers survey which included questions regarding provider's own and perceived client's reasoning for why pregnant women do not seek early and regular prenatal care.

D. STATE PERFORMANCE MEASURES

State Performance Measure 1: *Percent of women who smoked prior to pregnancy and report they stopped during pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	35.0	35.5	36.0	55	50
Annual Indicator	38.4	48.5	48.5	59.1	59.1
Numerator	131	178	178	198	198
Denominator	341	367	367	335	335
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	58	58	60	60	62

a. Last Year's Accomplishments

Risk assessed 3,556 clients in FFY 2004 and provided 3,219 visits to those clients eligible for case management services (the number of prenatal visits is significantly less than the previous year because the DOH now has the capacity to separate out completed vs. attempted visits; this capacity was not previously available). 247 clients deemed not eligible for case management services received one or two sessions of prenatal education.

Worked with the Tobacco Control Coordinator to review smoking cessation programs.

Provided smoking cessation materials to Bright Start and Baby Care clients.

Provided information to local CHNs regarding the South Dakota Quit Line.

Continued using computerized data collections and medical record documentation form to gather data on smoking behavior and exposure to second-hand smoke. Fifty one percent of clients risk assessed admitted smoking prior to knowledge of pregnancy while 30% continued to smoke during pregnancy and 24% reported smoking at the time of delivery. In addition, 40% of women lived with someone who smoked and 23% acknowledged being routinely exposed to secondhand smoke.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Educate professionals/public about risks associated with smoking during pregnancy.			X	
2. Educate Bright Start/Baby Care clients on risk factors associated with smoking during pregnancy.			X	
3. Provide tobacco cessation education/referral to pregnant clients identified as using tobacco.		X		
4. Review and evaluate smoking cessation programs.			X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Collaborating with March of Dimes, Perinatal Association, American Cancer Society, and CHAD to educate professionals/public about the risks associated with smoking during pregnancy.

Collaborating with Bright Start Home Visit program to educate clients on risk factors associated with smoking during pregnancy.

Risk assessing pregnant clients and provide case management services through Bright Start and Baby Care. Provide tobacco cessation education/referral services to clients identified as using tobacco.

Collaborating with Tobacco Control Coordinator to provide technical assistance to field staff

regarding strategies to assist clients with smoking cessation efforts.

c. Plan for the Coming Year

Collaborate with Bright Start home visiting program to educate clients on risk factors associated with smoking during pregnancy.

Risk assess pregnant clients and provide case management services through Bright Start and Baby Care. Provide tobacco cessation education/referral services to clients identified as using tobacco.

Improve case management services provided through Bright Start and Baby Care by means of policy development/revisions and quality assurance activities.

Review and analyze results from the 2005 Perinatal Health Risk Assessment survey of new mothers which includes questions regarding smoking and exposure to second-hand smoke during pregnancy.

Analyze data regarding risks and pregnancy outcomes through updated computer system.

Collaborate with the Tobacco Control Program to provide technical assistance to field staff to enhance efforts for providing smoking cessation strategies for clients.

State Performance Measure 4: *The rate (per 1,000 live births) of children under age one who die as a result of Sudden Infant Death Syndrome.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	1.8	1.8	1.7	0.1	0.1
Annual Indicator	1.5	1.4	1.1	1.3	1.3
Numerator	16	15	12	14	14
Denominator	10381	10446	10506	10732	10732
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	1.2	1.2	1.1	1.1	1.1

Notes - 2002

Numerator and denominator are 3 year averages.

Notes - 2003

Numerator and denominator are 3 year running averages.

a. Last Year's Accomplishments

Participated on the South Dakota Infant Loss Center Governing Board in an advisory capacity.

Collaborated with the Infant Loss Center to provide resources to CHS offices and referrals for post-SIDS support.

Accessed materials from the "Back to Sleep" campaign to provide to Baby Care and WIC clients.

Purchased "Back to Sleep" campaign materials to be used in the Bright Start Welcome Boxes.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Promote Back to Sleep Campaign.			X	
2. Include Back to Sleep materials in Bright Start Welcome boxes.				X
3. Promote Back to Sleep campaign with new parents through Bright Start, Healthy Starts, day cares, etc.				X
4. Collaborate with Infant Loss Center to promote Back to Sleep campaign.				X
5. Analyze 2003 Perinatal Health Risk Assessment survey which included questions regarding Back to Sleep.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Promoting the "Back to Sleep" Campaign to educate parents and other caregivers on how to reduce SIDS deaths and the importance of laying babies on their back to sleep.

Collaborating with the Bright Start Program to include SIDS and "Back to Sleep" materials in the welcome box for parents of newborns.

Collaborating with Bright Start home visit nurses, Healthy Start contacts, local health councils, DOH staff, Head Start, and registered/licensed day care providers to promote the "Back to Sleep" campaign with new parents.

Collaborating with Infant Loss Center to promote "Back to Sleep" campaign in South Dakota.

Analyzing results of 2003 Perinatal Health Risk Assessment survey of new mothers which included questions regarding "Back to Sleep" information.

c. Plan for the Coming Year

Promote the "Back to Sleep" Campaign to educate parents and other caregivers on how to reduce SIDS deaths and the importance of laying babies on their back to sleep.

Collaborate with the Bright Start Program to include SIDS and "Back to Sleep" materials in the welcome box for parents of newborns.

Collaborate with Bright Start home visit nurses, Healthy Start contacts, local health councils, DOH staff, Head Start, and registered/licensed day care providers to promote the "Back to Sleep" campaign with new parents.

Distribute report of the 2003 Perinatal Health Risk Assessment survey which included questions regarding "Back to Sleep" information.

Collaborate with Infant Loss Center to promote Back to Sleep campaign in South Dakota.

Collaborate with Aberdeen Area IHS and local service units on promoting the "Back to Sleep" campaign on the reservations.

Work with DSVR unit to map out location and race of SIDS deaths in the state.

State Performance Measure 5: *Percent of pregnancies which are unintended (mistimed or unwanted) and result in live birth or abortion.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	45.8	38.5	38.5	38.0	38.0
Annual Indicator	43.7	43.9	41.6	41.3	41.3
Numerator	4772	4853	4667	4770	4881
Denominator	10911	11054	11206	11544	11813
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	38.0	38	38	38	38

Notes - 2002
2002 data not available.

a. Last Year's Accomplishments

Provided family planning services to 14,220 clients in CY04. Of these clients, 9,707 were women over the age of 19 and 4,357 were adolescents aged 19 and under. Of the total clients, 10,757 were at or below 150 percent of poverty and 13,480 accessed a method of birth control.

During CY04, prevented 11,072 pregnancies through family planning services.

Provided community education regarding reproductive health/family planning to 2,630 adults.

Received additional Title X directed supplemental funding to provide cost effective and efficacious contraceptives and to increase community education and involvement.

Collaborated with the Title X training grantee JSI Research and Training to plan Reproductive Health Update which was held in October 2004 in Rapid City. Over 100 participants attended.

Collaborated with the University of Texas Southwestern Medical Center in Dallas to bring reproductive health clinician training to South Dakota in June 2004.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide family planning services to women at risk of unintended pregnancy.	X			
2. Provide community education to individuals/groups regarding reproductive health/family planning.			X	
3. Seek additional Title X supplemental funding to provide cost effective/efficacious contraceptives and community efforts/partnerships.				X
4. Plan and conduct 2005 Perinatal Health Risk Assessment survey of new mothers.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Continuing to provide counseling, education, medical, and contraceptive services to women at risk of unintended pregnancy.

Providing community education to individuals and groups regarding reproductive health and family planning topics.

Seeking additional funding through Title X directed supplemental funds to provide cost effective and efficacious contraceptives and continue expanded community efforts and partnerships.

Planning for, and conducting, the 2005 Perinatal Health Risk Assessment Survey of new mothers.

c. Plan for the Coming Year

Continue to collaborate with Title X to provide family planning services to populations at high risk for unintended pregnancy.

Provide community education to individuals and groups regarding reproductive health and family planning topics.

Collaborate on abstinence-only grant activities.

Provide technical assistance to professionals working with target populations regarding the issue of unintended pregnancy and programs that work to reduce unintended pregnancy.

Collaborate with Medicaid and managed care organizations to assure contraceptive coverage.

Disseminate information from the 2005 Perinatal Health Risk Assessment survey of new mothers.

State Performance Measure 7: *Percent of high school youth who self-report tobacco use in the past 30 days.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	44.0	40	40	30	30
Annual Indicator	44.0	33.0	33.0	30.0	30.0
Numerator	20201	15017	15017	13528	13528
Denominator	45911	45505	45505	45095	45095
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	30	30	29	29	28

a. Last Year's Accomplishments

Served on the DHS Alcohol and Drug Abuse Council.

Provided educational boards to CHS staff to facilitate efforts to inform parents and the community about the health effects of smoking, secondhand smoke and spit tobacco.

Collaborated with other state agencies to administer the Youth Risk Behavior Survey (YRBS) in high schools across the state. Results of the survey will be made available on the Tobacco Control Program's website with hard copies available upon request.

Provided quit line referral materials to DOH field offices, medical providers, tribal health, and other partners.

Utilized Prevention Resource Centers to distribute educational materials regarding tobacco use.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Sponsor community coalitions working on tobacco prevention at the local level.			X	
2. Sponsor statewide tobacco prevention conference.				X
3. Implement tobacco prevention education model in schools.			X	
4. Conduct counter marketing medical campaigns at state and local level.			X	
5. Provide statewide, telephone-based tobacco cessation services.			X	
6. Prepare/distribute report of the statewide Adult Tobacco Survey (ATS) and Youth Tobacco Survey (YTS).				X
7. Utilize data from ATS/YTS to refine program activities to address specific populations with higher tobacco use.				X
8.				
9.				
10.				

b. Current Activities

Issuing RFPs for community coalitions working on tobacco prevention at the local level.

Preparing for and sponsoring a statewide tobacco prevention conference to be held in August 2005 for members of tobacco prevention coalitions and other agencies and partners.

Working with DOE and Prevention Resource Centers to sponsor the implementation of an evidenced-based tobacco prevention education model in South Dakota school systems.

Conducting counter marketing media campaigns at the state and local level focusing on second hand smoke issues, reducing commercial tobacco use by Native Americans, and reducing tobacco use by pregnant women and youth.

Providing statewide, telephone-based cessation services via the Quit Line and education and resources to a variety of health professionals regarding the Public Health Service guidelines for treating tobacco use and dependence.

Utilizing data from the Youth Tobacco Survey and YRBS to refine program activities to address needs of specific populations with higher tobacco use such as American Indians, youth, young adults ages 18-24, pregnant women, and persons with low incomes.

c. Plan for the Coming Year

Sponsor and provide technical assistance to community coalitions working on tobacco prevention at the local level.

Work with DOE, DHS, local communities, and partners across the state to sponsor implement effective tobacco prevention education efforts.

Conduct counter marketing media campaigns at the state and local level.

Provide statewide, telephone-based cessation services via the South Dakota Quit Line along with education and resources to increase health professionals who assist tobacco users to quit.

Continue to provide technical assistance and resources to DOH staff, community groups, medical providers, and others working on tobacco prevention and control.

State Performance Measure 9: *Percent of school-aged children and adolescents who are overweight or obese.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	10.0	15.0	14.8	17.7	17.5
Annual Indicator	14.9	17.8	16.0	16.6	15.8
Numerator	2184	2187	2488	3214	4305
Denominator	14655	12285	15549	19362	27245
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	16.2	16	15.8	15.6	15.4

a. Last Year's Accomplishments

Continued to collect and analyze school height and weight data. One-hundred forty-five schools submitted data on over 20,000 students for the 2002-2003 school year. Data collected for the 2002-2003 school year showed 16% of South Dakota students were overweight or obese and a total of about 1/3 are at risk of becoming overweight or already overweight.

Provided 198 balance beam scales and measuring boards to 120 schools to improve school height and weight data quality and to assist schools who wish to participate in the project but can't due to lack of equipment

Presented data from the School Height and Weight Report as well as ways to prevent child obesity to a variety of organizations including school nurses, state recreation association, and state school food services personnel.

Provided print materials on child obesity to schools and others who serve youth. Materials were also available on the DOH web page.

Coordinated with DOE to support and/or assist schools with selection and implementation of comprehensive health education.

Collaborated with DOE to develop and sponsor South Dakota Schools Walk. This program promotes walking in schools as a way to increase physical activity among youth and help combat obesity. All elementary teachers were invited to register their classes online and receive free incentives for their students. To date, the program has tallied over 135 classroom/school registrations reaching thousands of students in South Dakota.

Promoted the use of CDC growth charts and prevention and treatment guidelines to health professionals.

Sponsored a downlink to multiple sites of satellite conferences on metabolic syndrome, obesity in Indian Country, and food allergies.

Spoke to a variety of groups regarding pediatric obesity and ways to combat including Healthcare Commission subcommittee, teachers, and Cooperative Extension. Co-sponsored the SDSU Nutrition Seminar on Type 2 diabetes in March. Over 300 people were in attendance.

Trained all local community health nurses and nutrition staff about pediatric obesity and appropriate counseling. Also provided training to school nurses, school food service personnel, and others who work with children and adolescents.

Collaborated with the Department of Game, Fish and Parks (GFP) to provide unique physical activity opportunities for youth through disc golf courses, equipment for family recreation and sponsored events promoting physical activity and nutrition.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Collect/analyze available school height-weight data and distribute to health/education providers.				X
2. Provide balance beam scales and measuring boards to schools to improve school height-weight data.			X	
3. Provide information on how to increase physical activity for children and adolescents			X	
4. Promote use of new CDC growth charts and prevention/treatment guidelines to health professionals.			X	
5. Collaborate with IHS to address overweight issues of Native American children.				X
6. Develop a new partnership with Youth Corrections at Custer to support life-long recreation and physical activity patterns.			X	
7. Collaborate with CDC Nutrition, Physical Activity and Obesity program to develop and implement a state plan to address obesity and plan/conduct campaign targeting youth to improve healthy eating and physical activity.				X
8. Collaborate with Coordinated School Health to support local school councils to provide physical activity, nutrition and tobacco prevention programs for school-aged youth.			X	
9. Collaborate with GFP to offer physical activity and nutrition programming in the state parks for families through recreation equipment, materials and programs			X	
10. Collaborate with OCHS and the SD Association for Health, Physical Education, Recreation, and Dance (SDAHPERD) to promote physical activity and healthy behaviors through health and physical education teachers for wellness activities.				X

b. Current Activities

Continued to collect and analyze school height and weight data for the 2004-2005 School Year. One-hundred ninety-eight schools submitted data on over 27,000 students for the 2003-2004 school year. Data collected for the 2003-2004 school year showed 16% of South Dakota students were overweight or obese and a total of 32% are at risk of becoming overweight or already overweight. A new pamphlet was also developed in addition to the full report. DOE Coordinated School Health and Team Nutrition partnered to send the pamphlet to all school administrators and partnered with Medicaid to send to all primary care providers. Working with DOE to computerize data collection.

In collaboration with the Nutrition and Physical Activity Program, provided 133 balance beam scales and measuring boards to schools to improve school height and weight data quality and to assist schools who wish to participate in the project but can't due to lack of equipment.

Providing educational information and materials to DOH staff and others for use with parents and schools on how to increase physical activity for all ages of children including strategies to decrease TV viewing.

Facilitating appropriate referral of obese children to medical providers for treatment including participating on the healthcare subcommittee of the Sioux Falls pediatric obesity planning group.

Participated as active member of the Interagency Healthy Weight Workgroup.

Utilize DOH website and the new Healthysd.gov website for consumer and provider resources on overweight children and adolescents.

Coordinating with DOE to support and/or assist schools with selection and implementation of comprehensive health education.

In collaboration with DOE, conducted South Dakota Schools Walk and developed, printed, and trained teachers on Minds in Motion, short classroom learning breaks, to promote physical activity in schools.

Co-sponsoring SDSU Nutrition Seminar on nutrition through the lifecycle which included information on pediatric obesity and sponsor satellite conferences on metabolic syndrome, pediatric allergies, and obesity in Indian country. Spoke to state education and health groups about healthy weight.

Collaborating with the Department of Game, Fish and Parks (GFP) to provide unique physical activity opportunities for youth through disc golf courses, recreation opportunities and events.

Participated in CDC Nutrition and Physical Activity plan development to prevent obesity and other chronic diseases.

c. Plan for the Coming Year

Collect, analyze and interpret available height-weight data for school-aged children and distribute information to appropriate health and education providers in an effort to reduce the percent of overweight children.

Provide balance beam scales and measuring boards to schools to improve school height and weight data quality and to assist schools who wish to participate in the project but can't due to lack of equipment. Schools from underrepresented areas will be targeted.

Provide educational information and materials to DOH staff and others for use with parents and schools on how to increase physical activity and healthy eating for all ages of children.

Collaborate with IHS and tribal health boards to address overweight issues of Native American children.

Continue to update and utilize Healthysd.gov website for consumer and provider resources on overweight children and adolescents.

Collaborate with DOE Coordinated School Health (CSH) and SD Association of Health, Physical Education, Recreation and Dance (SDAHPERD) to promote physical activity and healthy behaviors through health and physical education teachers for wellness activities.

Collaborate with CSH to offer the "South Dakota Schools Walk" Initiative for all students in public, private and BIA schools in the state.

Collaborate with CSH to revise and expand physical activity breaks for classroom teachers that reinforce core content standards and provide physical activity for students during the school day.

Collaborate with GFP to offer physical activity and nutrition programming in the parks for families through recreation equipment, materials and programs.

Develop a new partnership with Youth Corrections at Custer to support life long recreation and physical activity patterns.

Collaborate with Coordinated School Health to support local school councils to provide physical activity, nutrition and tobacco prevention programs for school age youth.

Collaborate with CDC Nutrition, Physical Activity, and Obesity program to develop and implement a state plan to address obesity. Plan and conduct campaign targeting youth to improve healthy eating and physical activity.

State Performance Measure 11: *Percent of children age 2-5 who are overweight or obese.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2000**	**2001**	**2002**	**2003**	**2004**
Annual Performance Objective			12	13	13.6
Annual Indicator	11.6	12.3	12.8	13.6	13.6
Numerator	1468	1029	1071	1146	1146
Denominator	12661	8368	8370	8423	8423
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**

Annual Performance Objective	13.4	13.2	13	12.8	12.6

Notes - 2003

Due to consistently increasing rate, the objective is to level off and then gradually decrease overweight among 2-5 year olds.

a. Last Year's Accomplishments

Provided print materials on child obesity to groups and providers serving preschool children. Materials were also available on the DOH web page.

Published PedNSS data report and distributed to local health offices and other interested partners.

Spoke to a variety of groups regarding pediatric obesity and ways to combat including Healthcare Commission subcommittee, early childhood enrichment and Cooperative Extension. Participated as active member of the Interagency Healthy Weight Workgroup which includes WIC, Head Start, and Child Care.

Updated DOH website and utilized new Healthysd.gov website for consumer and provider resources on overweight children.

Co-sponsored SDSU Nutrition Seminar on nutrition which included information on pediatric obesity and sponsor satellite conferences on metabolic syndrome, pediatric allergies, and obesity in Indian country. Provided training to Early Childhood Enrichment staff to increase age-appropriate nutrition and physical activity opportunities for preschool children.

Worked with Bright Start, WIC and others to educate parents and child care providers on the importance of good nutrition and physical activity for children.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide educational information/materials for parents on how to increase physical activity including strategies to decrease TV viewing.			X	
2. Collaborate with IHS to address overweight issues of Native American children.				X
3. Facilitate appropriate referral of obese children to medical providers for treatment.			X	
4. Collect, analyze and interpret available height-weight data for preschool children and distribute information to appropriate health and education providers.				X
5. Provide educational information and materials to DOH staff and others for use with parents and others who serve preschool children on how to increase physical activity and healthy eating for all aged of children.			X	
6. Work with Bright Start, WIC and others to educate parents on the importance of good nutrition and physical activity for their children.			X	
7. Update Healthysd.gov and DOH websites for consumer and provider resources on overweight children and adolescents.			X	

8. Collaborate with GFP to offer physical activity and nutrition programming in the parks for families through recreation equipment, materials and programs.			X	
9. Collaborate with CDC Nutrition, Physical Activity and Obesity program to develop and implement a state plan to address obesity and plan/conduct campaign targeting youth to improve healthy eating and physical activity.				X
10.				

b. Current Activities

Providing educational information and materials to DOH staff and others for use with parents and schools on how to increase physical activity for all ages of children including strategies to decrease TV viewing.

Facilitating appropriate referral of obese children to medical providers for treatment including working with the Sioux Falls pediatric obesity healthcare subcommittee.

Collaborated with Bright Start, WIC and others to educate parents on the importance of good nutrition and physical activity for their children.

Continued to update and utilized Healthysd.gov and DOH websites for consumer and provider resources on overweight children and adolescents.

Co-sponsored SDSU Nutrition Seminar on Nutrition through the Life Cycle and presented data on pediatric obesity. Sponsored satellite conferences on Common Pediatric Nutrition Problems, what America eats and obesity in Latino communities.

Started height weight monitor of Head Start data similar to School Height and Weight Report for interested Head Start Programs.

c. Plan for the Coming Year

Collect, analyze and interpret available height-weight data for preschool children and distribute information to appropriate health and education providers in an effort to reduce the percent of overweight children.

Provide educational information and materials to DOH staff and others for use with parents and others who serve preschool children on how to increase physical activity and healthy eating for all ages of children.

Promote the use of CDC growth charts and pediatric prevention and obesity treatment guidelines to health professionals.

Collaborate with IHS and tribal health boards to address overweight issues of Native American children.

Work with Bright Start, WIC and others to educate parents on the importance of good nutrition and physical activity for their children.

Continue to update and utilize Healthysd.gov and DOH websites for consumer and provider resources on overweight children and adolescents.

Collaborate with GFP to offer physical activity and nutrition programming in the parks for families through recreation equipment, materials and programs.

Collaborate with CDC Nutrition, Physical Activity, and Obesity program to develop and implement a state plan to address obesity. Plan and conduct campaign targeting youth to improve healthy eating and physical activity.

Distribute data and strategies on how to reduce television viewing by preschool children.

State Performance Measure 12: *Percent of infants who are breastfed at least 6 months*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective			42	42	42
Annual Indicator			41.7	41.7	36.3
Numerator			135	135	
Denominator			324	324	
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	42	43	43	44	44

Notes - 2003

Data was not available for years prior to 2002.

Notes - 2004

2003 NIS survey data. Numerator and denominator numbers were not available.

a. Last Year's Accomplishments

New performance measure.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	**ES**	**PBS**	**IB**
1. Participate on the South Dakota Breastfeeding Coalition.				**X**
2. Educate mothers in various DOH programs on the benefits of breastfeeding and provide support/ encouragement to initiate and continue breastfeeding.			**X**	
3. Provide information to health professionals, hospitals, worksites, and public promoting breastfeeding.				**X**

4. Update breastfeeding information on Healthysd.gov and DOH websites.				X
5. Develop, purchase and distribute materials for World Breastfeeding Week and for ongoing marketing of breastfeeding.			X	
6. Collaborate with Physical Activity program to promote continuation of breastfeeding to reduce overweight during childhood.			X	
7. Address breastfeeding environment and support in communities.				X
8. Partner with CDC nutrition and physical activity programs to develop and implement a statewide plan to improve breastfeeding rates.				X
9.				
10.				

b. Current Activities

Active participant on the South Dakota Breastfeeding Coalition to provide a networking system for breastfeeding education and promotion.

Educated mothers in the Bright Start home visiting, WIC and perinatal programs to provide support and encouragement to continue breastfeeding.

Provided information to health professionals, hospitals, worksites, and the public promoting breastfeeding.

Provided and updated breastfeeding information on the DOH website and utilized the new Healthysd.gov website to promote breastfeeding to parents, healthcare providers, and worksites.

Collaborated with WIC to develop, purchase and distribute materials for World Breastfeeding Week and for ongoing marketing of breastfeeding.

Collaborated with the Nutrition and Physical Activity program to promote continuation of breastfeeding to reduce overweight during childhood.

Co-sponsored SDSU Nutrition Seminar which included speakers on breastfeeding. Over 150 were in attendance.

The South Dakota WIC Program was awarded a grant from USDA to implement a Breastfeeding Peer Counselor Program. Breastfeeding Peer Counselors will work with WIC pregnant and breastfeeding women in Beadle, Brookings and Butte- Belle Fourche counties. The Breastfeeding Peer Counselors were trained using the Loving Support through Peer Counseling curriculum. The three Local Agencies have also received training on the Breastfeeding Peer Counselor program and how they can work as a team to educate and support breastfeeding WIC participants.

Best Start provided training on the Best Start 3 Step Counseling Strategy to the Local Agencies via DDN. The Best Start 3-Step Counseling Strategy(c) allows the healthcare provider to quickly determine each client's individual barriers to optimal health behavior, and to address those barriers effectively in encouraging positive health choices.

c. Plan for the Coming Year

Continue representation on the South Dakota Breastfeeding Coalition to provide a networking system for breastfeeding education and promotion.

Educate mothers in the Bright Start home visiting, WIC and perinatal programs on the benefits of breastfeeding and provide support and encouragement to initiate and continue breastfeeding.

Provide information to health professionals, hospitals, worksites, and the public promoting breastfeeding.

Continue to provide and update breastfeeding information on the DOH and Healthysd websites.

Collaborate with WIC to develop, purchase and distribute materials for World Breastfeeding Week and for ongoing marketing of breastfeeding.

Collaborate with the Nutrition and Physical Activity program to reduce the barriers to breastfeeding particularly in the workplace.

Partner with the Nutrition and Physical Activity program and OCHS to develop local coalitions to address breastfeeding environment and support in communities as well as provide resources to educators of prenatal and breastfeeding classes.

Partner with CDC nutrition and physical activity programs to develop and implement a statewide plan to improve breastfeeding rates.

E. OTHER PROGRAM ACTIVITIES

Preventive/Primary Care Services for Pregnant Women, Mothers and Infants --MCH perinatal program staff at the state, regional and community level provide services, offer technical assistance and partner with other agencies to improve the health of pregnant women, mothers and infants and impact pregnancy outcomes. Staff in the community provide direct case management and education services, link clients with appropriate resources and collaborate with public and private partners to assure access to services. Quality of services is assured through formalized activities at the state and local level. Client education materials are made available for both agency staff and private partners to utilize in the provision of services to this population. Training for professionals is provided directly or through collaboration with other agencies.

Preventive/Primary Care Services for Children and Adolescents -- DOH staff at the state, regional and community level provide services, offer technical assistance and partner with other agencies to improve the health of children and adolescents. Staff in the community provide developmental screening, immunizations, school screenings, health fairs, health education for school-age children, parent education, and participate locally on various advisory groups such as child protection teams, coordinated school health councils, interagency teams, etc. They share information and resources to facilitate referral to programs (i.e., CHIP, food stamps, and heating assistance). Program staff work with state agencies, organizations, communities, and partners to provide technical assistance to promote MCH programs. Program staff also participate on several workgroups facilitated by other state agencies.

Services for CSHCN -- State CSHCN staff at the state, regional and community level participate in numerous activities to enhance the capacity of the health and related service systems to identify and refer CSHCN in a timely and efficient manner. Networking and public education activities are ongoing by program staff. These activities also provide opportunities to discuss service delivery and other issues impacting CSHCN. MCH funds assist in the provision of respite care services for CSHCN, with staff also assisting in the application process as appropriate. The CSHCN program director also represents the program on the State Interagency Coordinating Council for Birth to Three as well as various other workgroups and committees at the state level.

F. TECHNICAL ASSISTANCE

The MCH program is committed to assuring that all MCH populations in the state receive the highest quality care and have optimal health. The MCH program is requesting technical assistance in examining the rates of women who report not gaining the ideal weight during pregnancy (i.e., 56.7% of pregnant women in South Dakota report gaining more than the ideal weight and 18.5% report gaining less than the ideal weight. Both affect pregnancy complications and birth outcomes.

The MCH program is fully aware of the disparities among the MCH population -- particularly among the Native American population. The MCH program will continue to explore ways to utilize MCH block grant funds to address these disparities in a manner that is workable for the state and recognizes the nine individual tribes and tribal governments in South Dakota. Should an opportunity be identified where technical assistance from MCHB would be appropriate, the MCH program will request assistance. At this time however, the MCH program is not requesting technical assistance in this area.

As was mentioned earlier, the MCH program interacts daily with the MCH population and related providers. This daily interaction allows the MCH program to respond to concerns or needs as they are raised. While the MCH program recognizes the need to improve its ability to obtain and interpret qualitative data for the MCH population, limited staff both within the DOH MCH program and with providers makes it difficult to devote the time necessary to conduct focus groups and other exercises designed to gather qualitative data. The MCH program will continue to explore feasible methods to work with providers and the MCH population to obtain needed data and input. As these methods are identified, the MCH program will request technical assistance if needed.

V. BUDGET NARRATIVE

A. EXPENDITURES

Activities performed by MCH program and field staff that provide services funded by the MCH block grant are accounted for by a daily time study. The time study includes funding codes that reflect the population that is being served (i.e., child/adolescent, pregnant women, mothers and infants, and CSHCN. Function codes determine if the service was direct, enabling, population-based, or infrastructure. Examples of this are developmental screening, immunization administration, travel to provide services, training, networking, quality assurance, and case management.

The budget amounts reflect anticipated activities of program and field staff but actual expenditures can vary based on the state economy and public health events (i.e., outbreaks, natural disasters). South Dakota law prohibits deficit spending so the Governor and state Legislature controls the spending of general funds that in turn affect dollars that are available for MCH block grant match.

B. BUDGET

MCH block grant funds have historically been used to address DOH priorities as outlined in the needs assessment and annual plan of the MCH block grant application. The comprehensive needs assessment process assists the DOH in setting priorities for resource allocation. The amount of funding to allocated to MCH services is determined as part of the state budget process that include development of the budget by the DOH, interim approval by the Bureau of Finance and Management (BFM) and Governor's Office, and final approval by the state Legislature.

The budget outlines areas for which Title V funds will be allocated. Development of the budget complies with the "30-30" requirement for primary and preventive care and special health care needs for children and adolescents and is consistent with the requirements to limit administrative costs to no more than ten percent. The DOH maintains the overall level of funds for MCH at the level established in FFY 1989.

Appropriation of general funds for MCH state match is at the discretion of the Legislature, Governor's Office and DOH. State match funding sources are state funds (including general funds appropriate by the Legislature), local match, program income, and other sources (i.e., Don't Thump Your Melon project private partners). No foundation or other private funding is currently available or utilized. The level of funds utilized from each match source varies from one year to the next based on availability of funds and the state's allocation process. Increasing inflationary costs have depleted revenue reserves within the DOH and the state as a whole and required shifts in match fund sources.

Budget development is subject to rules and requirements set by BFM that dictate both the process and content of the budget, including availability of funds and limitations on authorization levels. State MCH programs were first required to use the current format of reporting budgets and expenditures (including levels of the pyramid) in FFY 1999. Since that time, South Dakota has been refining the budget development and expenditure process to meet both state and federal rules and requirements. The DOH continues to work to move to accounting programs that more easily reflect population group and pyramid level reporting requirements.

Direct Health Services: A portion of the MCH block grant has traditionally been allocated to health service delivery (state-employed CHNs and nutritionists/dietitians) based on DOH time study data. For Alliance sites, services are contracted out to private agencies with DOH staff providing technical assistance to communities and maintaining its role of assessment, assurance and evaluation. DOH time study data tracks actual time spent delivering MCH services and activities. CHNs, dietitians, nutritionists, CSHS nurses, and social workers provide MCH services statewide to assure a local delivery system of quality public health services. The budget reflects the projected allocations to assure provision of postpartum/MCH home visits, family planning services and direct medical services for CSHCN. This allocation of funds enables a system of service delivery to assure essential health care services are available in rural areas of the state. The DOH continues to move to reduction of

direct health care services when appropriate.

Enabling Services: MCH block grant funds support activities to enhance access to care and assist consumers receive needed services (i.e., Bright Start toll-free number, care coordination for CSHCN and their families, translation, respite care, and parent support activities).

Population-Based Services: Allocations in this area support newborn metabolic screening, coordinated school health, injury prevention, bicycle safety, oral health, school screenings, community immunization coalitions, immunizations, outreach and public education, risk assessment of pregnant women, child health conferences/developmental screenings, and breastfeeding activities.

Infrastructure Building Services: Allocations in this area provide funding to support program staff, benefits, travel, operating, training, supplies, materials, capital outlay, and contractual services. Activities funded include needs assessment, community coordination/collaboration, community assistance, quality assurance, policy development, program planning and evaluation, interagency collaboration, training, technical assistance to field staff and public/private partners, and data collection and analysis.

VI. Reporting Forms-General Information

Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note

Please refer to Section IX of the Guidance.

X. Appendices and State Supporting Documents

A. Needs Assessment

Please refer to Section II attachments, if provided.

B. All Reporting Forms

Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents

Please refer to Section III, C "Organizational Structure".

D. Annual Report Data

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.